

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

THE CITY OF HUNTINGTON,

Plaintiff,

v.

CIVIL ACTION NO. 3:17-01362

AMERISOURCEBERGEN DRUG

CORPORATION, et al,

Defendants.

CABELL COUNTY COMMISSION,

Plaintiff,

vs.

AMERISOURCEBERGEN DRUG

CORPORATION, et al,

Defendants.

Videotaped and videoconference deposition of ANNE
LEMBKE, M.D., taken by the Defendants pursuant to the
West Virginia Federal Rules of Civil Procedure, in the
above-entitled action, pursuant to notice, conducted
virtually via Zoom, before Twyla Donathan, Registered
Professional Reporter and Notary Public, on the 17th day
of September, 2020.

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(All appearing via Zoom)

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1 P R O C E E D I N G S

2 VIDEOGRAPHER: Good morning. We're
3 going on the record at 10:31 a.m. on
4 September 17th, 2020.

5 Please note that the microphones are
6 sensitive and may pick up whispering, private
7 conversations, cellular interference. Please turn
8 off all cell phones and place them away from
9 microphones as they can interfere with deposition
10 audio. Audio and video recording will continue
11 unless all parties agree to go off the record.

12 This is Media Unit One of the video
13 recorded deposition of Anne Lembke, M.D., taken by
14 the Defendant in the matter of City of Huntington vs.
15 AmerisourceBergen Drug Corporation, et al, and Cabell
16 County Commission vs. AmerisourceBergen Drug
17 Corporation, et al, filed in the U.S. District Court
18 for the Southern District of West Virginia, Case Nos.
19 3:17-01362 and 3:17-01665.

20 This deposition is being held remotely
21 via Zoom conference. My name is Justin Ebiling. I'm
22 from Veritext. I'm the videographer. The court
23 reporter is Twyla Donathan, from Veritext.

24 I'm not authorized to administer an

1 oath. I'm not related to any party to this action,
2 nor am I financially interested in this outcome.

3 Counsel and all present please state
4 your appearance for the record.

5 MR. PYSER: I'll kick it off. This
6 Steven Pyser, from Williams & Connolly, appearing on
7 behalf of Cardinal Health, Inc., and with me today is
8 Brad Masters, also from Williams & Connolly.

9 MS. RODGERS: My name is Megan
10 Rodgers. I'm with Covington and Burling, on behalf
11 of McKesson, and with me today is my colleague,
12 Clayton Bailey.

13 MR. WEIMER: Good morning. This is
14 Jeffrey Weimer, with Reed Smith, on behalf of the
15 AmerisourceBergen Drug Corporation.

16 MR. ARBITBLIT: Good morning. Don
17 Arbitblit, Lieff, Cabraser, Heimann & Bernstein, with
18 Britt Cibulka for Plaintiffs.

19 MR. FARRELL: Good morning. Paul
20 Farrell, Jr., and Anne Kearse, on behalf of the
21 Plaintiffs.

22 VIDEOGRAPHER: Are there any
23 objections to the court reporter administering the
24 oath remotely?

1 MR. PYSER: No objections.

2 (Witness duly sworn)

3 A N N E L E M B K E

4 having been duly sworn, testified as follows:

5 EXAMINATION BY COUNSEL FOR CARDINAL HEALTH:

6 BY MR. PYSER:

7 Q Good morning, Dr. Lembke.

8 A Good morning.

9 Q Just to start off, I know you have been
10 deposed before in the MDL proceedings and the New
11 York proceedings, and then we had some court
12 testimony in the New York proceedings a week ago. Do
13 you recall that?

14 A Yes.

15 Q And you know that even though there is no
16 court reporter with you, or judge with you, you're
17 under oath today, just as if you were in a courtroom
18 in front of a judge and a jury. Do you understand
19 that?

20 A Yes.

21 VIDEOGRAPHER: Dr. Lembke, your audio
22 is breaking up a little bit. Is there any way you
23 can call in as well?

24 Let's go off the record. The time is

1 10:34. We're now going off the record.

2 (Pause in proceedings)

3 VIDEOGRAPHER: The time is 10:37.

4 We're now back on the record.

5 BY MR. PYSER:

6 Q All right. Dr. Lembke, well, that was
7 actually a good example, perhaps, of the issue that I
8 was just going to address with you, which is
9 especially in this remote environment, you and I will
10 just have to both work really hard not to speak over
11 each other. So I will try to let you answer the
12 question before I speak again, and if you could just
13 let me finish the question before you answer.
14 Hopefully that will help Twyla, our court reporter,
15 out. Make sense?

16 A Yes.

17 Q All right. And you may recall during the
18 hearing about a week ago with Judge Gargiulo that
19 there was at least one instance where he stepped in
20 and he instructed you to answer the question yes or
21 no. I'll do my best to ask you clear questions. If
22 you don't understand the question, just let me know,
23 but I would ask that you answer my questions as
24 they've been asked. Does that make sense?

1 A I will try my best to do that.

2 Q Okay. And I'm going to assume that if you
3 do answer my question, you understood the question or
4 you would have told me so. Does that make sense?

5 A Yes.

6 Q All right, Doctor. We're going to be
7 concentrating today on your work for Cabell and
8 Huntington in West Virginia. Are you familiar with
9 those two places?

10 A Yes, I am.

11 Q Okay. And were you hired by the plaintiffs
12 in a case filed against Cardinal Health,
13 AmerisourceBergen, and McKesson Corporation to
14 provide an expert report in litigation filed by
15 Cabell and Huntington?

16 A Yes, I was.

17 Q Okay. And did you create such a report?

18 A Yes, I did.

19 Q Well, let's try the other thing we've got
20 to work with in this remote environment. Do you have
21 a box of documents with you today that was delivered
22 to your office or maybe your home?

23 A Yes, I do.

24 Q Okay. There should be in that box one

1 that's marked Exhibit 1 or have a 1 on it somehow.

2 Do you see that?

3 All right. Can you pop that one open for
4 me. And once you have done so, can you identify
5 Exhibit 1.

6 A This is my report.

7 Q Okay. Does that report contain the
8 opinions you intend to offer in this litigation?

9 A Yes, it does.

10 Q And does it contain a comprehensive
11 explanation of the opinions you intend to offer?

12 A Yes, it does.

13 Q When did the plaintiffs in this case, in
14 the West Virginia case, retain you as an expert?

15 A I believe it was December 2019.

16 Q And at that time in December 2019 you had
17 already been working for the plaintiffs in other
18 opioid litigation; is that right?

19 A That is correct.

20 Q And that included plaintiffs in what we
21 sometimes call Track One in the MDL, so the
22 plaintiffs in Ohio?

23 A Yes, for the plaintiffs in Ohio.

24 Q And the plaintiffs in New York as well?

1 A That is correct.

2 Q Okay. Any other plaintiff groups you were
3 working with in December 2019?

4 MR. ARBITBLIT: Objection. Instruct
5 not to answer as to any retentions in which you have
6 not been disclosed as an expert. And I don't think
7 there are any others.

8 BY MR. PYSER:

9 Q Are you going to follow your counsel's
10 advice?

11 A I'm going to follow my counsel's advice.

12 Q Are you paid in this case, the
13 West Virginia version of the litigation?

14 A Yes, I am.

15 Q And just throughout the day, to allow us to
16 use shorthand, even though we're really only talking
17 about one county and one city, sometimes I will say
18 the West Virginia litigation. You understand that
19 when I say that, I mean this case, correct?

20 A Yes, I do. And thank you for clarifying.

21 Q Do you know how many hours you've spent on
22 work for the West Virginia litigation?

23 A I do know. They're in my invoice -- my
24 invoices. I didn't add them up for today, but I do

1 have that information and I could get it for you.

2 Q Do you know approximately how many hours
3 you've worked on the West Virginia litigation?

4 A I didn't add up the hours.

5 Q Okay. Could you do that, and through your
6 counsel provide me that total number of hours?

7 A Yes.

8 MR. ARBITBLIT: That's agreeable.

9 MR. PYSER: Thank you, counsel.

10 Q And how much are you paid per hour for your
11 work in the West Virginia case?

12 A Five hundred dollars per hour for report
13 preparation, and \$800 per hour for court testimony.

14 Q And are you getting the extra \$300 an hour
15 that you charge for court testimony for being here
16 today in a deposition?

17 MR. ARBITBLIT: Objection.

18 A I assume so.

19 Q Do you know how much money in total you've
20 earned from your work on opioid cases?

21 MR. ARBITBLIT: Objection. Instruct
22 not to answer.

23 Steve, I don't know if you're on the
24 same page with other defense counsel. I've seen

1 back-and-forth, that appears to me to agree that that
2 question is off limits for both sides, and that
3 Dr. Lembke is -- has already provided what has been
4 agreed, which is the number of hours on this case and
5 the hourly rate.

6 If you have a different understanding,
7 I'd like to see the documentation of it. I'm not
8 trying to be an obstructionist in any way. I am just
9 trying to follow the ground rules that I understand
10 have been agreed to by counsel for both sides. So
11 for the moment, I'm going to instruct her not to
12 answer that.

13 MR. PYSER: Dr. Lembke, I'm assuming,
14 again, you're going to follow your counsel's advice?

15 THE DEPONENT: Yes, I am.

16 MR. PYSER: Okay. And Counsel, that's
17 fine, if that's the agreement. You know, in the
18 event that there is some breakdown in the agreement,
19 we reserve the right to come back and get an answer
20 to the question. But if that's consistent with the
21 agreement, that will be fine.

22 BY MR. PYSER:

23 Q Dr. Lembke, in the prior cases where you
24 provided an expert report in Ohio and New York, you

1 understand there were different groups of defendants,
2 manufacturers, pharmacies, distributors; is that
3 right?

4 A Yes, I understand that.

5 Q But here in this case, are you aware that
6 there is only distributors?

7 A Yes. I am aware of that.

8 Q And there's three distributors, Cardinal
9 Health, AmerisourceBergen, and McKesson? Do you
10 understand that?

11 A Yes, I do.

12 Q So here in this case, when we talk about
13 the distributors, you understand we're talking about
14 those three, right?

15 A I understand that, yes.

16 Q You reviewed documents in preparing your
17 report, correct?

18 A Yes.

19 Q And you're aware that in the litigation,
20 more generally, including this case in West Virginia,
21 the case in Ohio, the case in New York,
22 manufacturers, distributors, pharmacies, they
23 produced millions of pages; do you understand that?

24 A Yes, I do.

1 Q Okay. In order to select the documents you
2 reviewed for purposes of this case, the West Virginia
3 case, did attorneys provide you with documents that
4 might be relevant to your report?

5 A I asked attorneys for documents that I
6 wanted to see that I thought would be relevant.

7 MR. ARBITBLIT: Instruct her not to
8 answer further about communications with counsel.

9 Q And are you going to follow your counsel's
10 advice?

11 A (Deponent nods)

12 Q In your report you cited more than 600
13 articles that helped to form the basis of your
14 West Virginia report; is that right?

15 A That is correct.

16 Q For each of those articles, did you read
17 the full article?

18 A Yes.

19 Q So you never just stopped at the abstract,
20 you read every word of every article?

21 A Yes.

22 Q And how about the documents that were
23 produced in this case and that are cited in your
24 report, did you read every page of those as well?

1 A Yes.

2 Q And the deposition transcripts that you
3 cite in your report, did you read every page of the
4 depositions you were provided as well?

5 A These are the deposition transcripts from
6 other witnesses?

7 Q Correct.

8 A No, I did not always read every word of
9 those. I often skimmed those.

10 Q In order to know what was the important
11 material, how did you figure out when you were
12 skimming what you should read and shouldn't read?

13 MR. ARBITBLIT: Objection. Instruct
14 not to answer as to any discussions with counsel.

15 MR. PYSER: Can you answer that
16 question without divulging your conversations with
17 counsel?

18 A So after many decades of reviewing
19 documents, I think I'm pretty good at being able to
20 speed-read some sections, look for relevant material
21 that I need to know and then to read that material
22 more closely.

23 Q Before your work in this litigation, had
24 you ever reviewed legal transcripts of depositions?

1 A No.

2 Q Because you were deposed twice before, I
3 just want to make sure we're on the same page about
4 those depositions. And I guess there is two
5 depositions, and we talked earlier about the third
6 time you gave testimony, which was in court before
7 Judge Gargiulo, right?

8 A Yes.

9 Q Okay. So in those three prior instances of
10 testimony, if you think back to those, have your
11 answers to the questions you were asked in those
12 three prior instances of testimony changed in any
13 way?

14 MR. ARBITBLIT: Objection.

15 A Sometimes, because the circumstances were
16 changed. The truthful answer was different or I
17 understood the question differently (...trailing).

18 (Court reporter asked for clarification; poor
19 audio transmission by witness.)

20 MR. PYSER: Let's go off the record.

21 VIDEOGRAPHER: The time is 10:49.
22 We're now going off the record.

23 (Pause in proceedings)

24 VIDEOGRAPHER: The time is 10:56.

1 We're now back on the record.

2 THE DEPONENT: Can I -- Can we strike
3 that, and can I try to answer it again? Because I
4 don't think you got exactly what I said.

5 MR. PYSER: You can answer again. Go
6 ahead.

7 THE DEPONENT: Can you ask it again,
8 actually? We'll just rewind. Can you ask it again?

9 (The reporter read back the following
10 as requested: "Okay. So in those three prior
11 instances of testimony, if you think back to those,
12 have your answers to the questions you were asked in
13 those three prior instances of testimony changed in
14 any way?")

15 THE DEPONENT: Yes, they have, but I
16 was always telling the truth as I understood it.

17 BY MR. PYSER:

18 Q Can you provide for me a list of the
19 answers that have changed?

20 MR. ARBITBLIT: Objection. That's
21 your job, Counsel. You've got all the transcripts.
22 I'm not going to have the witness go through
23 transcripts to answer that question. You've got the
24 transcripts.

1 BY MR. PYSER:

2 Q You can answer the question, Dr. Lembke.
3 Are you able -- and if the answer is no, the answer
4 is no. Are you able to give me, sitting here today,
5 a list of the answers that have changed in your
6 testimony from the Ohio deposition and the New York
7 deposition and the New York examination?

8 A No, I'm not able to give you that list.

9 Q All right, Dr. Lembke.
10 Dr. Lembke, I want to just let you know,
11 and for the record, note that at 6:39 p.m. last night
12 I received an email, as did the other counsel for
13 defendants, with 54 new documents on it that was
14 described as "Materials Considered."

15 And so between 6:39 p.m. last night -- and
16 here we are at 10:59 a.m. this morning, I will
17 represent to you that at 6:39 last night, personally
18 I was coaching a little league team, and my paralegal
19 had left for the day.

20 So I'm trying to -- We're scrambling a
21 little bit to understand those documents. So my
22 question to you is: One of those documents, for
23 example, was the label for OxyContin, the FDA
24 approved label. And that was listed as a material

1 considered for this case. When was the first time
2 you reviewed that label for purposes of this case?

3 MR. ARBITBLIT: Objection.

4 A I don't remember.

5 Q Okay. Was it yesterday?

6 A No.

7 Q Was it within the last week?

8 A I don't remember exactly. I certainly
9 reviewed it multiple times over a longer period.

10 Q So the first time you looked at it was
11 likely more than a month ago; is that fair?

12 A Yes.

13 Q And were you the person who decided not to
14 notify the defendants of that until 6:39 p.m. last
15 night?

16 MR. ARBITBLIT: Objection.

17 A I'm not involved in notifying defendants
18 about that. My job is to review the material and to
19 generate the report and to defend my opinion.

20 Q Okay. And is it possible -- Do you know
21 what I'm talking about when I say a list of 54
22 materials considered that was sent last night? Have
23 you seen that document?

24 A I haven't seen the document, but I do know

1 that it was sent.

2 Q So you've never -- the actual document with
3 54 documents listed on it, you've never seen that,
4 correct?

5 A I've not seen the list. I've seen the
6 document.

7 Q And Dr. Lembke, I'm also going to represent
8 to you that some of those documents, they have Bates
9 numbers on them. Do you know what that means?

10 A Yes, I do.

11 Q And some of those documents aren't even
12 available to defendants. So Dr. Lembke, I just want
13 to be fair to you and let you know that as a result
14 of that, we might need to come back and ask you
15 additional questions at a later deposition about
16 those documents. Understand?

17 A I understand.

18 MR. ARBITBLIT: And we'll just state
19 for the record, Counsel, that those are provided with
20 a letter that said that they don't -- they're not
21 offered to alter in any way the opinions or add to
22 the opinions stated in the report. They're provided
23 simply to comply with the rule as to anything the
24 witness has reviewed.

1 So as far as coming back for a further
2 deposition, our position is everything you need is in
3 the report and the documents previously provided. We
4 have an obligation under the rule --

5 MR. PYSER: Counsel, enough. You can
6 send us a letter and state your position. That's
7 fine. I'm going to ask the witness questions now.

8 MR. ARBITBLIT: You've already
9 received that letter, Steve. You've already received
10 that letter, the one you talked about, said exactly
11 what I just said.

12 MR. PYSER: Great. So I don't need to
13 hear it again.

14 MR. ARBITBLIT: You apparently didn't
15 read it the first time.

16 BY MR. PYSER:

17 Q Dr. Lembke, is it possible that in
18 answering a question here today or at trial you may
19 rely on one of those 54 documents that was sent along
20 last night?

21 A Yes.

22 Q Okay. Dr. Lembke, you also sent last
23 night -- or counsel sent last night something that
24 was described as an errata. Are you familiar with

1 that?

2 A Yes.

3 Q Okay. And that changed a chart that was at
4 page 127 of Exhibit 1. Are you familiar with that?

5 A Yes, I am. It was a very minor correction,
6 and the correct answer was, in fact, there.

7 Q Okay.

8 A Yes, I am aware.

9 Q So that's helpful, because maybe we're on
10 the same page, because maybe it was late and my eyes
11 were bleary, but I couldn't actually see the change.
12 So can you tell me what the change is on page 127?

13 A Sure. Can you show it, or would you like
14 me to just walk you through it?

15 Q Tell me, if you look at page 127 of Exhibit
16 1, in your own words, what's changed, in a general
17 fashion?

18 A Okay. So you see that on the right-hand
19 side of the graph, there's medium dose and low dose.

20 Q Yes.

21 A And there are values under medium dose on
22 the graph, it says 28.26. But if you look below,
23 where it lists medium dose in the text, it says
24 28.69.

1 The correct value is the 28.69, but for
2 some reason, it was mistyped. So it's essentially a
3 typo.

4 Q Okay.

5 A And the same things for low dose. On the
6 graph it says 17.42, below it says 14.92. The
7 correct is 14.92. Again, it's just a small typo in
8 the actual graph. We try to be as accurate as
9 possible.

10 Q I appreciate that. When did you realize
11 that that -- when did you first recognize that
12 typo -- or that issue?

13 A Yesterday.

14 Q Okay. Thank you.

15 Dr. Lembke, you received your medical
16 degree from Stanford in 1995, correct?

17 A Yes.

18 Q And did you receive offers to attend
19 medical schools other than Stanford?

20 A Well, that's going way back. Yes, I did.

21 Q Why did you choose Stanford?

22 A I chose Stanford because my sister was here
23 as an undergraduate and really liked it. I came out
24 to visit her. Seemed like a great place. The

1 program at Stanford Medical School seemed like an
2 excellent program. I thought moving to California
3 seemed good. Those types of things that one makes
4 those decisions on when one is young.

5 Q Fair enough. And you've been teaching at
6 Stanford since 2003; is that right?

7 A I really have been teaching here since I
8 was a medical student. I was a TA as a medical
9 student. I did teaching in my fellowship and
10 residency, but I joined the faculty in 2003. So then
11 it became official.

12 Q So an official teacher or professor at
13 Stanford for 17 years, right?

14 A Yes.

15 Q About. Are you familiar with the process
16 by which Stanford Medical School determines the
17 curriculum that it's going to teach its medical
18 students?

19 A Yes.

20 Q How does that work? I'm not asking about
21 anything in particular, just as a general matter, how
22 is it decided? What are we going to teach the next
23 generation of doctors?

24 A It's based largely on doctors coming

1 together and deciding as a group what the priorities
2 are for medical students in a given era, but that's
3 not the only source of decision-making. It's also
4 become increasingly a reciprocal process, where
5 students themselves are vocal about what they think
6 they need to learn. There are also national measures
7 and national guidelines that influence what is taught
8 at a given time. So it's multifactorial.

9 Q And do the individual professors obviously
10 help decide what is going to be taught in their
11 particular classes?

12 A They do help decide, but it's also embedded
13 by other groups of educators. There has been a shift
14 in medical education over the last 20 years to become
15 more clinical, more clinically oriented for a number
16 of reasons.

17 Q Are you part -- personally, are you part of
18 the group that helps design the curriculum at
19 Stanford?

20 A I have been involved for at least the last
21 five years in creating an addiction medicine
22 curriculum at Stanford, as well as revising parts of
23 the pain curriculum at Stanford, yes.

24 Q And is it fair to say that the doctors who

1 over the years that you've been at Stanford have
2 worked on the curriculum are smart doctors? I mean,
3 they're Stanford professors, right?

4 MR. ARBITBLIT: Objection.

5 A Yeah, you can be a Stanford professor and
6 be really smart and also be misinformed.

7 Q Fair enough. The doctors designing the
8 curriculum at Stanford, in your view have they been
9 operating in good faith when they've designed the
10 curriculum for Stanford medical students?

11 MR. ARBITBLIT: Objection.

12 A What do you mean by "in good faith"?

13 Q Trying to do the right thing.

14 MR. ARBITBLIT: Objection.

15 A I think that Stanford professors, like all
16 humans, are motivated by a complex mix of factors.
17 Some, in trying to do the right thing, is what
18 motivates some people, and other people have other
19 motivations, or there are other motivations in the
20 mix. So it really depends on the person.

21 Q Well, if -- As a member of the faculty for
22 the last 13 years at Stanford, can you name for me
23 any of your colleagues on the faculty who in the
24 design of the Stanford Medical School curriculum you

1 believe were operating in bad faith when they worked
2 on the curriculum?

3 MR. ARBITBLIT: Objection.

4 A Yeah, I wouldn't want to name names, but I
5 do think there have been individuals who have been
6 heavily influenced by the pharmaceutical industry.

7 Q And by pharmaceutical industry, do you mean
8 manufacturers of pharmaceuticals?

9 A I mean the opioid pharma more broadly.

10 Q Can you, sitting here today, point me to
11 any interaction between a professor at Stanford and
12 Cardinal Health?

13 A No.

14 Q How about AmerisourceBergen?

15 A No.

16 Q And McKesson Corporation?

17 A No.

18 Q And I'll ask you again. Are you willing to
19 name the professors at Stanford, who, in your view,
20 have been improperly influenced by the pharmaceutical
21 industry?

22 MR. ARBITBLIT: Objection.

23 A I would be reluctant to do that.

24 Q I'm not asking if you're reluctant. Will

1 you do it or not?

2 A Not at this time.

3 Q So you're refusing to answer my question?

4 A I feel like that was an answer.

5 Q Well, just so we're clear. Sitting today,
6 you're not going to give me the names of the
7 professors I asked you for?

8 MR. ARBITBLIT: Objection.

9 A Not today.

10 Q We've been through your background before,
11 so I'm not going to repeat it, but one area we
12 haven't covered is economics. And I want to make
13 sure we're clear. Do you have a degree in economics?

14 A No.

15 Q Okay. Have you ever authored any peer
16 reviewed papers in the field of economics?

17 A No, but I have spoken at an economics
18 conference.

19 Q What was the subject of your speech?

20 A The opioid problem.

21 Q Do you consider yourself an expert on
22 economics?

23 A No.

24 Q Have you ever been to West Virginia,

1 Doctor?

2 A No.

3 Q And I'm going to go out on a limb and say
4 that if you've never been there, you're not licensed
5 to practice medicine in West Virginia either?

6 A That's correct.

7 Q Are you familiar with the term standard of
8 care in the context of the practice of medicine?

9 A Yes, I am.

10 Q What does that mean, standard of care?

11 A It basically means that you're practicing
12 in the way that people around you are also
13 practicing.

14 Q Is standard of care synonymous with best
15 practices?

16 MR. ARBITBLIT: Objection.

17 A Not always.

18 Q So what does best practices mean, if it's
19 different than standard of care?

20 A In its idealized form, best practices would
21 be the height of evidence-based medicine.

22 Q And are there organizations and entities
23 that set standards for doctors?

24 A Yes.

1 Q And do they do so under the standard of
2 care or do they try to set best practices?

3 MR. ARBITBLIT: Objection.

4 MR. PYSER: You can answer, Doctor.

5 A It really depends on the organization and
6 what they've been influenced by.

7 Q Well, I'm not asking your opinion of the
8 eventual standards they set, okay? I'm just asking
9 when an organization -- let's say a board of
10 medicine, all right? Do boards of medicine set
11 standards of care?

12 MR. ARBITBLIT: Objection.

13 A They can. They have done.

14 Q And do they also set best practices? How
15 would you describe what a board of medicine for an
16 individual state sets? Is it a standard of care or
17 is it best practice?

18 MR. ARBITBLIT: Objection.

19 A It seems to me that you're kind of creating
20 a false dichotomy between standard of care and best
21 practices, which is making it hard for me to answer.
22 For example, the standard of care in opioid
23 prescribing in the 1990 (distorted audio), which was
24 also touted as best practices, which was put forward

1 by organizations like the drug commission and the
2 federation of state medical boards, was indeed what
3 everybody was doing, because they were told to do
4 that, but it wasn't evidence-based medicine.

5 Q Okay. So at the time, in the 1990s when it
6 comes to the prescribing of opioids, doctors thought
7 what they were doing was best practices and in
8 accordance with the standard of care, correct?

9 MR. ARBITBLIT: Objection.

10 A Doctors were taught that prescribing
11 opioids for chronic pain was evidence-based medicine
12 even though there was no evidence to support it.

13 Q That wasn't my question. My question was:
14 At the time, did doctors believe that their opioid
15 prescribing was both best practices and consistent
16 with the standard of care?

17 MR. ARBITBLIT: Objection.

18 A I don't think that most doctors are even
19 familiar with the term standard of care, so I don't
20 think they would have thought about it in those
21 terms.

22 Q It's your position that most doctors aren't
23 familiar even with the concept of standard of care;
24 is that right?

1 A That's right.

2 Q Is that a failure by the medical community?

3 MR. ARBITBLIT: Objection.

4 A My understanding is that standard of care
5 is a term that mainly comes up in legal proceedings.
6 It's not something that doctors talk about. We don't
7 talk about standard of care in medical school. We
8 don't talk about that in residency. It's not a term
9 that doctors -- it's not our language.

10 Q Well, having now spent some time in our
11 legal world here, what's the closest equivalent in
12 the medical world -- how do doctors know what they
13 should be doing, how they should be prescribing?
14 Where do they turn?

15 MR. ARBITBLIT: Objection.

16 A Doctors base their decisions on a
17 combination of what they learned in medical school,
18 what they learned in residency, what they see their
19 attending professor doing during their training.
20 Medicine works very much like an apprenticeship.
21 There is a saying in medicine, do one, see one, teach
22 one. So there is this sense of going along with the
23 herd, whatever people are doing.

24 Q So when it comes to the prescription of

1 opioids, do you have views -- yes or no, do you have
2 views as to whether certain prescribing habits of
3 doctors are appropriate or not?

4 A Yes.

5 Q And today, in 2020, do you believe it's
6 appropriate for a doctor to prescribe opioids to
7 treat chronic non-cancer pain?

8 A In some very rare instances, yes.

9 Q And has your view of that changed over the
10 years? Have you always believed that, or has that
11 view changed?

12 A My view on that has changed since my
13 education in medical school in the 1990s, and my
14 early residency training, yes, my view has changed.

15 Q Are you able to put a date on when your
16 view changed as to the appropriateness of prescribing
17 opioids to treat chronic non-cancer pain?

18 A My view evolved over years, so I cannot put
19 a single date on it. It was the accumulation of
20 evidence after I graduated from medical school and
21 the accumulation of my experiences with my patients,
22 what I read in the medical literature. I arrived at
23 it slowly. It wasn't that I woke up, you know, one
24 day and it changed my opinion. It was the

1 accumulation of the evidence that led me to change my
2 opinion.

3 Q And that accumulation, just so we put some
4 concrete years on it, it happened between 2003, I
5 believe, when you graduated from medical school? Do
6 I have that right?

7 A It probably started more like the year
8 2000, 2001, where I began to wonder about what I had
9 been taught in medical school regarding the use of
10 opioids in the treatment of pain.

11 Q And that evolved over the next 20 years
12 until today, correct?

13 A Well, I would say that the primary
14 evolution occurred in the first decade, which led me
15 to want to write a book about it to inform other
16 doctors, as well as the lay public, culminating in
17 the publication of my book in 2016.

18 I think since that time, my essential views
19 have not changed substantially. I have learned more,
20 reviewed more, seen more, but my opinion, in essence,
21 has remained the same since the publication of my
22 book.

23 Q Doctor, do you know whether under current
24 medical guidelines it's appropriate for a doctor to

1 prescribe a 30-day supply of opioids to treat acute
2 pain?

3 MR. ARBITBLIT: Objection.

4 A So there are many different guidelines, so
5 I can't answer that question as if there were only
6 one guideline. Also, guidelines are quickly changing
7 as the medical community realizes that they were
8 duped. So it's hard for me -- you really have to
9 point to one specific guideline.

10 Q Let me ask it this way, Doctor. Do you
11 know whether for a doctor in West Virginia it's, in
12 your view, appropriate medical practice to prescribe
13 a 30-day supply of opioids to treat acute pain?

14 MR. ARBITBLIT: Objection.

15 A I'm trying to remember the various
16 guidelines that I've reviewed for West Virginia. I
17 have reviewed some guidelines. I cannot remember the
18 specifics about the limits on opioid prescribing, but
19 I am aware that there are more recent guidelines that
20 are strongly urging doctors to cut back on opioid
21 prescribing because of the harm that they've caused.
22 But I don't remember the exact number of days.

23 Q When we talk about these guidelines, and
24 best practices, and standard of care, all the words

1 we've been using, are you aware of any mandatory
2 guidelines on doctors in West Virginia that dictates
3 how they can prescribe opioids?

4 MR. ARBITBLIT: Objection.

5 A Right now I'm not recalling any mandatory
6 guidelines. There may be. I'm not recalling that
7 there are any. There are certainly a lot of
8 recommended guidelines. I recall recommended
9 guidelines to doctors in West Virginia. And then, of
10 course, there are the CDC guidelines.

11 Q When we talk about these recommended and
12 CDC guidelines, they rely on doctors to use their
13 professional judgment to decide what is appropriate
14 for an individual patient, correct?

15 MR. ARBITBLIT: Objection.

16 A That's incorrect.

17 Q So do doctors not have to exercise their
18 judgment to decide what prescription is appropriate
19 for a patient?

20 MR. ARBITBLIT: Objection.

21 A I guess I'm having a little trouble
22 understanding the line of questioning. So in
23 creating guidelines, clinical experience matters but
24 it's not the only thing that informs guidelines. And

1 I felt like your question implied that it was only
2 clinical experience that informs guidelines. So I
3 wanted --

4 Q I'm sorry, Doctor. I'm actually moving
5 beyond guidelines. I now want to ask about an
6 individual doctor practicing medicine, let's say, in
7 Huntington, West Virginia.

8 A Yes.

9 Q That doctor has available to them a range
10 of guidelines, correct? CDC guidelines, for example?

11 A It really depends on the clinic setting and
12 that individual's education. Not every doctor has
13 access to every single guideline. There are a lot of
14 guidelines out there. Doctors are incredibly busy.
15 They often will rely on the algorithm or guidelines
16 that their specific treatment setting has said to
17 them they need to follow.

18 Q Okay. So if --

19 A So doctors -- you know, doctors are super
20 busy seeing patients. They don't have time to read
21 every single guideline and digest it. They rely on
22 opinion leaders, the last continuing medical
23 education course they went to, the hospital quality
24 measures. They're mostly trying to do the right

1 thing but also follow the rules, and the rules are
2 often the guidelines that somebody, who manages their
3 hospital and manages their clinic settings, says,
4 here, you got to follow these. That's -- honest to
5 goodness, that's the real world. That's the real
6 world.

7 Q Doctor, when you write a prescription, you
8 sign your name on the bottom of it, correct?

9 A Yes, I do.

10 Q And is that normal practice for doctors
11 when they write a prescription, they sign their own
12 name, correct?

13 A (Nods.) Yes, there are circumstances where
14 nurse practitioners are working under doctors'
15 licenses, so technically the nurse practitioner is
16 signing, but it's still under the doctor's name. But
17 yes.

18 Q So we'll make this simple. This is a
19 doctor talking to a patient, going to prescribe
20 something, the doctor signs their name to the
21 prescription, correct?

22 A That's correct.

23 Q And by signing their name, that doctor is
24 exercising their medical judgment as to what's

1 appropriate for that patient, correct?

2 MR. ARBITBLIT: Objection.

3 A Not always.

4 Q In what circumstance is a doctor not
5 exercising their own medical judgment when they write
6 a prescription for a patient?

7 A Many different circumstances.

8 Q Okay. So doctors -- Can you name a
9 circumstance where a doctor is not responsible for
10 their own prescribing decisions?

11 MR. ARBITBLIT: Objection.

12 A Well, now you said being responsible.
13 Ultimately, we're responsible, which puts a big legal
14 burden on us, but that's different from what informed
15 their decision to write the prescription.

16 My light just went out. I have one of
17 these motion sensor things.

18 Q So, Dr. Lembke, doctors are ultimately
19 responsible for their own prescribing decisions,
20 correct?

21 MR. ARBITBLIT: Objection.

22 A Doctors are medically/legally responsible
23 for their prescribing decisions.

24 Q Is that a yes?

1 A Yes.

2 Q In your practice, do you regularly
3 prescribe controlled substances?

4 A Yes.

5 Q And your patient population, is it
6 primarily people who are dealing with addiction?

7 A Yes, but they also have other
8 co-morbidities, like chronic pain.

9 Q But the patients you're seeing, maybe they
10 have chronic pain, maybe they have other
11 co-morbidities, a consistent threat throughout most
12 of the patients you're seeing is that they suffer
13 from some type of addictive disease; is that right?

14 A I have a large percentage of patients who
15 don't, in fact, meet criteria for addiction. They
16 meet criteria for dependence. But the majority of my
17 patients have some kind of chemical
18 dependency/addiction. So those are distinct
19 phenomena.

20 Q And in your practice, do you adapt your
21 practice of medicine to new research as it comes out?

22 A Yes.

23 Q What questions do you believe a physician
24 needs to answer before prescribing opioids to a

1 patient?

2 MR. ARBITBLIT: Objection.

3 A That's a very long list. I don't think
4 that I could encapsulate that in a succinct answer.

5 Q It's a complicated question? Is that fair?
6 Let me rephrase that. Strike that.

7 Is it a complicated question for a
8 physician to make a determination as to whether
9 opioids are appropriate for a particular patient?

10 MR. ARBITBLIT: Objection.

11 A Some aspects of it are very simple. For
12 example, the fact that opioids don't work for chronic
13 pain. So that wouldn't be complicated. But other
14 aspects of the rare instances in which opioids might
15 be helpful for a patient, that requires a lot of
16 stewardship and due diligence.

17 Q And, Dr. Lembke, to your knowledge, do all
18 doctors agree with your view that opioids don't work
19 for chronic pain?

20 A When I first started talking about this
21 problem, the fact that the way that we are
22 prescribing opioids was not evidence-based, and the
23 risk of addiction was extremely high, there were very
24 few doctors who agreed with me. I was really

1 swimming upstream. I think in the last five years or
2 so, there's been a change as more doctors come to
3 recognize the opioid crisis and the role that they
4 have played in it, and we've seen a change in
5 prescribing as a result. But there are still doctors
6 who may not share my opinion.

7 Q You keep part of your answer off the time
8 when you first started talking about your belief that
9 opioids don't work for chronic pain. Can you help me
10 understand, when was that when you first started
11 talking about your belief that opioids don't work for
12 chronic pain?

13 A I became aware of the problem in the early
14 off, because I was seeing more and more patients
15 addicted to --

16 Q That wasn't my question. My question is
17 when did you first start talking about that in a
18 public setting and transmitting that information to
19 other doctors, your belief?

20 MR. ARBITBLIT: Objection.

21 A It's hard for me to remember exactly, but
22 probably sometime in the first decade of this
23 millennium, somewhere between the year 2000 and 2010.
24 Because I do a lot of teaching, you know, so I guess

1 if you think of that as a public forum, I'm always
2 teaching medical school students and residents,
3 talking to colleagues.

4 Q How about outside Stanford Medical School?
5 When did you first start talking about your belief
6 that opioids don't work for chronic pain?

7 A Probably 2012.

8 Q We talked in a prior deposition -- or I
9 actually wasn't answering the question, but you
10 talked about what you would do if a pharmacy couldn't
11 fill a patient's prescription. Do you recall some
12 conversation about that?

13 A Yes, I do.

14 Q Okay. And you were asked -- this is the
15 question. I'll read it to you.

16 And, Counsel, this is from page 49,
17 line 18, of the New York deposition.

18 "And so if one of your patients said that
19 they couldn't fill a prescription for opioids because
20 the distributor wouldn't ship to that pharmacy, and
21 you went through all the circumstances of the patient
22 and you determined that this patient needed opioids,
23 what would you tell the patient to do?"

24 And your answer was: "Probably the first

1 thing I would do would be to contact the pharmacy
2 directly and try to figure out what the circumstances
3 were of their not having a particular medication."

4 Okay? I just want to follow up a little
5 bit on that subject. Putting yourself back in that
6 position where you have now called the pharmacy, if
7 the pharmacy told you that they didn't have a
8 medication in stock at that pharmacy because a
9 distributor, like the defendants here, had declined
10 to ship that medication that you prescribed, what
11 would you tell your patient to do?

12 MR. ARBITBLIT: Objection.

13 A Well, first, I would ask the pharmacist why
14 the distributor had declined to ship the medication.
15 I would try to understand if there was some
16 compelling reason why it wasn't shipped.

17 Q If at the end of those conversations the
18 pharmacy said "We can't get that medicine in stock,"
19 would you instruct your patient to go to another
20 pharmacy?

21 MR. ARBITBLIT: Objection.

22 A I'm not really sure. That's never happened
23 before where, you know, it was a great mystery. You
24 know, usually I could get some information on why it

1 wasn't there and then use that information to decide
2 what to do in the absence of that.

3 Q Do you in your medical practice -- do you
4 ask your patients where they plan to fill the
5 prescriptions that you write for them?

6 A I have to do that to know where to send the
7 prescription.

8 Q So as a general matter, you ask each
9 patient who you write a prescription for where they
10 plan to fill it?

11 A I have to look up the pharmacy in the
12 computer in order to send it to that pharmacy. Now,
13 that's really quite new. When I went to medical
14 school and early in my training, I gave patients a
15 piece of paper and they took it wherever they wanted
16 to go. I didn't know where they went. I didn't have
17 control of them where they went. It's really only in
18 the last five to ten years with the advent of
19 electronic medical records that I input the pharmacy
20 to electronically send the prescription, so that I
21 have some awareness.

22 But truthfully I don't know where many of
23 these pharmacies are. I'm not particularly, you
24 know, aware of where the pharmacy is or exactly which

1 pharmacy. I'm just trying to get what address they
2 tell me.

3 Q So beyond putting a pharmacy name or an
4 address into the computer system, when you write a
5 prescription, do you talk to the pharmacist who's
6 going to fill that prescription as a regular
7 practice?

8 MR. ARBITBLIT: Objection.

9 A Often. Yes. Especially controlled
10 substances.

11 Q And approximately what percentage of your
12 prescription writing today do you talk to the
13 pharmacist who's going to fill the prescription?

14 A Probably more than 50 percent.

15 Q But not every time?

16 A Not every time.

17 Q Dr. Lembke, I know you've never been to
18 West Virginia, but I want to try to talk a little bit
19 about what you may know and not know about opioid
20 prescribing in Cabell County and Huntington,
21 West Virginia. Okay?

22 Do you agree with me that at least some of
23 the opioid prescriptions in Cabell County and
24 Huntington were appropriate prescriptions, even under

1 your belief and standards?

2 A Yes.

3 Q Okay. So fair if we call that category the
4 Dr. Lembke-approved prescriptions, Category 1?

5 A Yes.

6 Q Is that fair?

7 A That's okay.

8 Q Thank you, Doctor. So let's think about
9 another category -- well, actually let's stay with
10 the Dr. Lembke-approved category. Do you have any
11 idea what percentage of prescriptions in Cabell
12 County and Huntington fall into the Dr. Lembke-
13 approved category?

14 A So I don't really want to weigh in on like
15 percentages and quantities. In my report I do have
16 an appendix where I talk about what appropriate
17 prescribing is, and I'm happy to go to my report and
18 talk more about that. But I don't --

19 Q I'm asking you sitting here today,
20 Dr. Lembke, if you can give me a percentage. And if
21 you can't, that's okay. So what I'm asking you is:
22 Dr. Lembke, can you give me a percentage of the total
23 prescriptions for opioids in Cabell County and
24 Huntington, West Virginia, that you believe were

1 appropriate medical treatment?

2 MR. ARBITBLIT: I would just say
3 before you answer, that's a fair question, but I
4 would just ask, Steve, that when she's in the middle
5 of an answer, give her the courtesy of finishing
6 before you go to the next question. That will make
7 it easier for you and the witness and the court
8 reporter.

9 BY MR. PYSER:

10 Q Absolutely. Dr. Lembke, if I ever cut you
11 off, just let me know, and I'll do my best to stop
12 that, okay? Do you need the question read back to
13 you?

14 A No.

15 Q Okay. Go ahead then.

16 A Okay. So to quantify it, I would look at
17 the way that prescribing nationally has quadrupled in
18 the last -- since the 1990s in the United States,
19 which roughly estimated means we are currently
20 prescribing more -- say in the peak of 2012, we were
21 prescribing four times more opioids than we should
22 have been, because there was no increase in the need
23 for analgesia in the population at that time.

24 Likewise, if you look at West Virginia,

1 there was a similar and maybe even a higher increase
2 in opioid prescribing in West Virginia without any
3 increase during that span of time in the need for
4 analgesia. In my report, which I am happy to go to,
5 you know, I have numbers showing the number of
6 prescriptions written per 100 persons in
7 West Virginia, which especially if you're looking at
8 Cabell County are more than twice the national
9 average.

10 So already you have an increase over time,
11 a quadrupling over time since the 1990s to 2012, and
12 then you have in Cabell County a real outlier
13 situation where at peak prescribing, people in Cabell
14 County were getting twice as many opioids as in the
15 rest of the United States. So that is how I would
16 quantify that.

17 Q So is it fair to say that approximately --
18 strike that. If nationwide there has been a
19 quadrupling in your view of prescriptions for
20 opioids, and the appropriate level is the level
21 before that multiplication by four, that the
22 appropriate level is something like one quarter of
23 the current level nationwide; is that a fair
24 extrapolation of your view?

1 MR. ARBITBLIT: Objection. Misstates
2 the record.

3 A Yeah, I think that what I was saying was
4 that on top of that quadrupling nationally there was
5 an even bigger disproportionate overprescribing
6 problem in Cabell County. So, again, hard for me to
7 put, you know, a number on it. But suffice it to
8 say, way too many opioids have been prescribed in
9 Cabell County than were medically necessary.

10 Q When you compare Cabell County to the rest
11 of the nation, have you done any analysis yourself to
12 see if Cabell County has different or higher rates of
13 certain health concerns than the rest of the country?

14 A I do understand that Cabell County is a
15 working community of people who may have higher rates
16 of obesity-related arthritis, mechanical injuries
17 from manual labor. I am aware of that. I haven't
18 done my own calculations, however.

19 Q So you haven't done any analysis to
20 determine how the fact that Cabell County has higher
21 rates of, for example, obesity-related arthritis or
22 working injuries may impact the needs for opioids
23 within the community?

24 MR. ARBITBLIT: Objection.

1 A No, but regardless of the pain levels in
2 Cabell County, they don't justify the increased
3 opioid prescribing in that county.

4 Q Dr. Lembke, you didn't answer my
5 question --

6 A --

7 Q No, well -- look, we want to get through
8 this day as fast as possible, and I think it can be a
9 short day, but you're going to have to answer the
10 questions that I'm asking, okay? So my question was
11 just simply: Have you done an analysis of Cabell
12 County versus the rest of the country to determine
13 whether health differences in the population in
14 Cabell County may have impacted the prescribing rate
15 in Cabell County versus the nation, and if so, by how
16 much? Have you done that analysis, yes or no?

17 MR. ARBITBLIT: Objection. Vague --
18 Let me state the objection. Objection. It's vague,
19 ambiguous, not the same question.

20 You may answer.

21 A Yes. So I'm having problems with the way
22 that you're framing the question. I'm not trying to
23 be obstructionistic, but the frame of your question
24 implies that if Cabell County has higher rates of

1 pain, that would justify higher rates of prescribing.
2 And that I cannot agree with.

3 Q Okay. Let's take out the prescribing from
4 it. Have you done an analysis, yes or no, to
5 determine whether Cabell County has higher rates of
6 pain than the national average?

7 A I have not done my own analysis on that.

8 Q Are you familiar with any studies or other
9 analyses that compares the rate of pain in Cabell
10 County to the rest of the nation?

11 A I'm not recalling specific articles, but I
12 can tell you that I have read articles and reports
13 that attest to Cabell County possibly having higher
14 rates of some pain conditions.

15 Q Thank you, Doctor. So we talked about the
16 first category, the Dr. Lembke-approved
17 prescriptions. And we haven't quantified it, and
18 that's fine. I want to move on to a second category.

19 Is it fair to say that some of the opioid
20 prescriptions in Cabell County were written for what
21 doctors believed in good faith, based on what they
22 were taught in medical school, was for a legitimate
23 medical purpose, even though you might disagree with
24 that? Is that a fair category of prescriptions that

1 we might encounter in Cabell County?

2 MR. ARBITBLIT: Objection.

3 A Yes. I mean, it's hard to answer that
4 without, you know, a specific patient example, but
5 yes, I would say that that's fair.

6 Q In your MDL report you opined that that
7 category, doctors who wrote in good faith opioid
8 prescriptions but shouldn't have, accounted for the
9 vast majority of opioid prescriptions. Is that true
10 for Cabell County and Huntington as well?

11 A By that answer what I meant was really that
12 there's been a paradigm shift in opioid prescribing
13 such that all doctors were prescribing more opioids
14 based on misleading statements by the defendants.
15 So -- and that pill mill doctors are a real problem,
16 but they're a minority of the problem. And I think
17 that that conceptualization also applies to Cabell
18 County.

19 Q So again, Doctor, we'll just try to keep it
20 simple. So my question was: Is it true that in
21 Cabell and Huntington the majority of prescriptions
22 written were written by doctors who were operating in
23 good faith, but shouldn't have written the opioid
24 prescriptions that they did, in your view?

1 A Yes.

2 Q So now we've got two categories. We've got
3 the Dr. Lembke category, and we've got the doctors we
4 just talked about.

5 Let's talk about a third category, okay?
6 These are unlawful prescriptions. Are you aware of
7 any unlawful prescriptions for opioids in Cabell
8 County or Huntington?

9 A I'm aware that that generally occurred. I
10 don't have specific examples.

11 Q What would you need to know in order to
12 make a determination of what percentage of
13 prescriptions in Cabell County were unlawful or in
14 bad faith by the doctors?

15 A Part of what I would look at is just the
16 sheer volume of prescribing and dispensing in a given
17 area.

18 Q I'm talking about the prescribing now. So
19 in order to know if an individual doctor's
20 prescription was unlawful or written in bad faith,
21 what would you need to know in order to make that
22 determination?

23 A Well, one of the first things and one of
24 the sentinel things that I would need to know was the

1 number of prescriptions being written, because I have
2 a very good idea, being a clinician myself, of what
3 it takes to really evaluate a patient and decide
4 whether or not opioids are indicated, as well as
5 monitor and steward that prescription. And it takes
6 time.

7 So if there were a prescriber who were
8 prescribing very large volumes of opioids, and a
9 pharmacy that was dispensing very high volumes of
10 opioids, that would be one of the first things that I
11 would look for.

12 Q And in order to make a judgment about that,
13 Doctor, would you need to see the medical records of
14 the patients for whom they were prescribing?

15 A It would really depend on the degree to
16 which the volumes were egregious. I mean, if the
17 volumes were just astronomically high, I almost
18 wouldn't need to see anything else, because I know
19 what one person can do in the span of, you know, a
20 given workday. Obviously, I would want to look --
21 obviously I would want to look at all the material,
22 but it would be much less important if that data
23 point were a huge outlier.

24 Q So we can agree that it would be helpful in

1 your analysis of whether a prescription is
2 appropriate or not to see the medical records of the
3 patients for whom the prescriptions were written,
4 fair?

5 A You know, I can imagine a scenario where I
6 would not need to look at the medical records.

7 Q I'm asking you as a general matter, Doctor,
8 if you were trying to make a determination as to
9 whether prescribing by a physician was appropriate or
10 not, would it be helpful for you to see the medical
11 records of that doctor's patients?

12 MR. ARBITBLIT: Objection.

13 A Again, I feel like I've answered this
14 question and given, you know, a scenario that I think
15 answers the question.

16 Q Doctor, is it your view that medical
17 records are irrelevant to a determination of whether
18 or not a doctor's prescribing practices are
19 appropriate?

20 MR. ARBITBLIT: Objection.

21 A There are scenarios in which medical
22 records could be irrelevant.

23 Q And that would only be in a scenario where
24 the volume written by a particular doctor was so high

1 that it's your belief that it has to be illegitimate
2 prescribing; is that fair?

3 A That's not the only scenario, but I think
4 that's one scenario.

5 Q Is that the most common scenario for an
6 instance where you don't think the medical records
7 would be useful to your analysis of prescribing?

8 MR. ARBITBLIT: Objection.

9 A I'm not going to quantify that -- that
10 example. There are many, many different types of
11 circumstances.

12 Q Okay. What are the other circumstances in
13 which medical records would be irrelevant to your
14 review of whether a prescription was appropriate or
15 not?

16 A If the physician, him or herself, was
17 obviously impaired, would be an example.

18 Q What else?

19 A Those are the two that I can think of now.

20 Q So if the physician was impaired, or if the
21 sheer volume is so high for a particular doctor,
22 those are the two scenarios under which medical
23 records would not be needed to analyze whether the
24 doctor was prescribing appropriately, correct?

1 MR. ARBITBLIT: Objection.

2 A Those are two that I can think of now.

3 Q Can you think of any other now?

4 A Pardon me?

5 Q Can you think of any others, sitting here
6 today, can you think of any other scenarios?

7 A No. I've never been presented with this
8 particular narrow question. I could think on it more
9 and get back to you.

10 Q Sitting here today, can you think of any
11 others?

12 A I cannot.

13 Q Dr. Lembke, can you name for me any doctor
14 in Cabell or Huntington who you believe prescribed
15 opioids improperly or illegally?

16 A No.

17 Q Do you know the percentage of opioid
18 prescriptions written in Cabell County that were
19 written for the purpose of treating acute pain?

20 A No.

21 Q Do you know the percentage of opioid
22 prescriptions written in Cabell County and Huntington
23 that were written for the purpose of treating chronic
24 non-cancer pain?

1 A No.

2 Q Do you know the percentage of opioid
3 prescriptions written in Cabell County and Huntington
4 that were written for the purpose of treating cancer?

5 A No.

6 Q How about end-of-life or hospice care?

7 A No.

8 Q Dr. Lembke, can you name for me, sitting
9 here today, any doctor or pharmacy in Cabell County
10 or Huntington that you would describe as a pill mill?

11 A No, I'm not aware of a specific pill mill
12 in Cabell County or Huntington.

13 Q Doctor, I want to return for a moment to
14 something you talked about in your MDL deposition so
15 that I can ask you a couple of follow-up questions
16 about it, all right?

17 Do you recall -- and this is, for counsel,
18 at page 241 of the MDL deposition. You stated -- you
19 were -- strike that. In your MDL deposition, we
20 referred to some notes that you had taken. Do you
21 recall those notes? They were handwritten notes of
22 yours?

23 A You mean on the report itself?

24 Q Yes. It actually wasn't on the report. It

1 was a series of notes that were introduced as an
2 exhibit to your MDL deposition.

3 A From my book?

4 Q Yes.

5 A Yes, I do remember.

6 Q And one of those notes said, quote:

7 "Some colleagues' goal is just to keep the
8 ED moving, just get them out the door, time and
9 space. One trusted colleague said: Just give them
10 what they want."

11 Do you recall that?

12 A I do recall that, yes.

13 Q And those were from notes you had taken
14 when you were preparing your book, correct?

15 A Yes, from my qualitative interviews, which
16 was the research for my book.

17 Q And what does "keep the ED moving" mean?

18 A So that was an interview with a young woman
19 who had just graduated from her training, who was an
20 emergency medicine doctor who was working in an
21 emergency department. And she expressed to me how
22 demoralized she was that she had to base her clinical
23 practice, in part, on not just -- not necessarily
24 explicit rules, but implicit expectations around

1 seeing large numbers of patients quickly in that
2 emergency room. So that was the context for that.

3 Q Thank you for that. The line, "One trusted
4 colleague said 'just give them what they want,'" is
5 that a colleague of yours or was that a colleague of
6 the woman you interviewed?

7 A Yes, so that was a colleague of mine.

8 Q What's the name of the colleague of yours
9 who told you, quote, "just give them what they want"
10 in reference to patients who were asking for opioids?

11 MR. ARBITBLIT: Objection.

12 A I don't know the name of that person.

13 Q You told me it was one of your colleagues,
14 correct?

15 A I'm sorry. I think -- So the person I
16 interviewed who told me that, she said that one of
17 her colleagues told her that. Does that make sense?

18 Q It does. I think we got our signals
19 crossed. So not a colleague of yours, a colleague of
20 the woman you interviewed?

21 A That's right.

22 Q And did you ask your interviewee the name
23 of the colleague who stated "just give them what they
24 want" in reference to people asking for opioid

1 prescriptions?

2 A I don't remember if I asked her. If I did,
3 she probably didn't disclose it.

4 Q Do you believe that kind of practice of
5 medicine, just giving patients what they want when
6 they ask for opioids, is appropriate?

7 A No.

8 Q Do you believe it puts patients' welfare at
9 risk?

10 A Yes.

11 Q Does it pose an immediate threat to the
12 health and safety of patients for a doctor to
13 prescribe opioids in that manner?

14 MR. ARBITBLIT: Objection.

15 A Generally speaking, I guess the answer is
16 yes.

17 Q Do you believe a doctor who, when a patient
18 presents at the emergency department and asks for
19 opioids, just gives them what they want, is violating
20 state licensing provisions?

21 MR. ARBITBLIT: Objection.

22 A I wouldn't simplify it to that degree, no.
23 I think that's an oversimplification.

24 Q Did you report this incident where you

1 learned of a doctor whose approach to prescribing
2 opioids in an emergency department was to just give
3 patients what they want, did you report that to any
4 medical board or any conduct-setting organization?

5 A No, because I think what that comment gets
6 at is the culture of the place where she was working,
7 rather than --

8 Q --

9 MR. ARBITBLIT: Let her finish.

10 MR. PYSER: Understood. Finish your
11 answer, Dr. Lembke. I apologize.

12 A So, to me, that captured a culture in
13 medicine where that kind of behavior was -- became
14 acceptable, even when doctors knew that what they
15 were doing maybe wasn't the best thing for patients.
16 There were so many pressures on them to see patients,
17 to prescribe opioids, to have satisfied customers, to
18 meet Joint Commission quality measures. Have you
19 done quote/unquote everything in your power to
20 eradicate this patient's pain -- unquote, from, you
21 know, closed quote, anyway.

22 So that speaks to that culture, such that
23 it became what was expected of doctors, which again
24 is why the subtitle of my book is that doctors were

1 duped. And as I do elaborate on in my book, "caught
2 in the system," which made it very difficult for them
3 to use their clinical judgment, right? And to make
4 clinical decisions that would have been best for
5 patients.

6 Q So you spoke about the culture at the place
7 where this interviewee was working. Where was she
8 working?

9 A I don't remember the name of the hospital.
10 I probably have it somewhere in my notes. But in my
11 book I wasn't going to name specific individuals or
12 hospital settings per se.

13 Q So fair to say you didn't report the
14 hospital to the state medical board or any other
15 standard setting organization?

16 A That's fair to say.

17 Q Do you have a duty as a doctor to report
18 incompetent or unethical behavior by colleagues?

19 MR. ARBITBLIT: Objection.

20 A So, you know, there are lots of incompetent
21 and unethical things that go on in the workplace. It
22 really matters, the degree of the incompetence and
23 the lack of integrity, and the certainty with which I
24 have that it occurred. So.

1 Q Doctor, so, yes or no, do you have an
2 obligation if you are aware of incompetent or
3 unethical behavior by colleagues, do you believe you
4 have a reporting obligation when you observe that?

5 MR. ARBITBLIT: Objection.

6 A It totally depends on the circumstance.
7 There are many degrees of being unethical and
8 incompetent.

9 Q Dr. Lembke, have you ever reported a
10 physician to a state medical board?

11 A I don't believe so.

12 MR. ARBITBLIT: Dave, we've been going
13 for just over an hour since the break. Do you want
14 to take ten minutes?

15 MR. PYSER: Let me take another two
16 minutes or so, and then we'll be at a decent stopping
17 point, if that's all right with you.

18 MR. ARBITBLIT: Okay.

19 THE DEPONENT: I just -- I guess I
20 want to add --

21 MR. PYSER: We're at a good stopping
22 point. It's fine.

23 THE DEPONENT: Okay.

24 MR. PYSER: We can cut some questions.

1 All right. Let's go off the record.

2 VIDEOGRAPHER: The time is 12:02.

3 We're now going off the record.

4 (A recess was taken.)

5 VIDEOGRAPHER: The time is 12:12. We
6 are now back on the record.

7 BY MR. PYSER:

8 Q Dr. Lembke, in prior reports and in your
9 report here in West Virginia, you used the term
10 "pharmaceutical opioid industry." Do you recall
11 using that word in your reports?

12 A Yes, I do.

13 Q Does the term pharmaceutical opioid
14 industry have the same meaning in your West Virginia
15 report as it did in your report and testimony in New
16 York and Ohio?

17 A Yes.

18 Q So on page 180 of your report, Exhibit 1,
19 you state that: "Today's opioid crisis would not
20 have occurred without the paradigm shift encouraged
21 by the pharmaceutical opioid industry, whose actions
22 resulted in the overprescribing and excessive
23 distribution of prescription opioids."

24 That's toward the bottom of page 180. Did

1 I read that correctly?

2 A Yes.

3 Q And the paradigm shift you're referring to
4 there, did it begin in the 1980s with the advent of
5 the hospice movement?

6 MR. ARBITBLIT: Objection.

7 A As I've written before, the 1980s was the
8 beginning of the change in thinking and culture
9 around opioids, and then the real increase in
10 prescribing happened in the 1990s. So, you know,
11 medicine moves slowly and changes slowly, and the
12 thinking began to change in the 1980s.

13 Q And the thinking that began to change in
14 the 1980s, was it related to something known as the
15 hospice movement?

16 A I believe so, yes.

17 Q What was the hospice movement?

18 A The hospice movement was the awareness that
19 we had an aging population, that more and more people
20 were struggling at the very end of life, and that we
21 as health care providers had a responsibility to ease
22 their passage and to make people more comfortable at
23 the very end of life, the last two weeks or so.

24 Q And was part of the hospice movement's goal

1 to make people more comfortable at the end of their
2 life, was part of the way that they accomplished that
3 goal the use of opioids to treat pain at the end of
4 life?

5 A To treat pain, but also frankly to speed up
6 death, to, you know -- opioids, as you know, slow
7 down breathing, slow down the heart rates. So it was
8 kind of an -- almost a form of sanctioned euthanasia
9 at the very end of life.

10 Q Is it your view that the hospice movement
11 is a form of sanctioned euthanasia?

12 MR. ARBITBLIT: Objection.

13 A Well, that language is perhaps too strong,
14 but I do stand by the view that the goal of hospice
15 is to make people more comfortable as they are dying,
16 which, you know, de facto can mean to help them die.

17 Q Can we agree, Dr. Lembke, that making
18 patients comfortable at the end of their life is a
19 good thing?

20 MR. ARBITBLIT: Objection.

21 A We can agree on that, yes, if the
22 intervention that's used actually accomplishes that
23 goal.

24 Q And are there patients for whom opioids

1 assist in relieving pain at the end of their life?

2 A Yes. Not just relieving pain, but also
3 helping them to die.

4 Q All right. I'm going to ask you, yes or
5 no -- and, you know, you said you wanted to end the
6 day early. That's fair. Dr. Lembke, we're moving at
7 a snail's pace because when you answer questions and
8 you go on and on, that's what happens. And you might
9 recall Judge Gargiulo instructing you, just answer
10 the question, in a little bit of an exasperated way.
11 So, you know, I don't have the robe --

12 A I don't recall him being exasperated with
13 me.

14 MR. ARBITBLIT: Steve, you're the one
15 that's acting in an exasperated way. So just answer
16 the questions and keep it moving. Ask the question
17 and keep it moving. We don't need a lecture. We do
18 not need your lectures. The witness doesn't need
19 your lectures. Just ask your question.

20 BY MR. PYSER:

21 Q Let's proceed. So, Dr. Lembke, do you
22 agree that opioids can assist in relieving pain of
23 patients at the end of their lives, yes or no?

24 A I agree with that statement only in a

1 qualified way, which is to say that if the opioids
2 are used for no longer than two to four weeks, I
3 agree. If the use is prolonged, I do not agree. And
4 I'm happy to explain why that is if you would like.

5 Q So, Dr. Lembke, do you agree that it's
6 appropriate to use opioids to relieve pain at the end
7 of life for a two- to four-week period?

8 MR. ARBITBLIT: Objection.

9 A In patients for whom it appears to do just
10 that for no more than approximately two to four
11 weeks, I agree that that's appropriate, yes. Because
12 again, it's not just relieving pain, it's actually
13 helping them to die.

14 Q Doctor, is that a mainstream medical view
15 that doctors who are prescribing opioids in the
16 hospice care are helping patients die?

17 MR. ARBITBLIT: Objection.

18 A I think that it's a mainstream view that
19 hospice is there to assist with the process of death.

20 Q And is it your understanding that doctors
21 who specialize in hospice care are hastening their
22 patients' death by prescribing opioids? Is that your
23 position?

24 A I think that's perhaps stated too strongly.

1 But I have worked in hospice settings, I have been at
2 the bedside of relatives who have died at hospice,
3 and it was clearly communicated by my attending
4 physician and my training, as well as by the hospice
5 nurse in my personal circumstance, that the opioids
6 would make the patient both more comfortable and also
7 help them die.

8 Q And is that an appropriate or an
9 inappropriate use of opioid medication?

10 MR. ARBITBLIT: Objection.

11 A I believe that opioids in the last couple
12 of weeks of life to help the passage to death is an
13 appropriate use, if done under the supervision of a
14 trained health professional.

15 Q Doctor, I'd like to turn with you in
16 Exhibit 1 of your report to Appendix III --
17 Exhibit 1, which is your report, I should say. And
18 this is a section of your report in which you look at
19 case specific data for Cabell County and the City of
20 Huntington, correct?

21 A Can you tell me what page you're on?

22 Q Sure. It's page 237, which is Appendix III
23 of Exhibit 1 to this deposition.

24 A Yes. That's the cover page, right? But is

1 there a specific --

2 Q Well, as you look at the next page, it says
3 "case specific data and information." Correct?

4 A Yes.

5 Q And it looks at -- specifically at Cabell
6 County and the City of Huntington, correct?

7 A Yes.

8 Q And in that analysis you look at -- you
9 rely upon the report of Craig McCann. He's the first
10 citation. It's footnote 641 to your report.

11 A Yes.

12 Q Okay. And Dr. McCann, are you aware that
13 he was relying on ARCOS data?

14 A I am not specifically recalling that, but
15 I'll take your word for it.

16 Q Okay. Do you know what ARCOS data is?

17 A Yes.

18 Q So it's data submitted by distributors and
19 other entities reflecting the number of pills that
20 are supplied to a given either distributor or
21 pharmacy. Is that a fair description of what lies
22 within ARCOS?

23 A Yes, it is.

24 Q On page 241, paragraph 3, you state that:

1 "Opioid prescribing in Cabell County and
2 West Virginia significantly exceeded the rate for the
3 United States generally." Do you see that?

4 A Yes.

5 Q And is it your opinion that that's a
6 reliable conclusion that you've reached?

7 A Yes.

8 Q And the way you reached this opinion on
9 prescribing is based on the distributions that were
10 shipped to West Virginia and to Cabell County and
11 recorded in ARCOS, correct?

12 A Yes.

13 Q And that's because the number of pills that
14 a distributor ships to a particular place, such as
15 West Virginia, is closely correlated with the number
16 of pills prescribed to patients in that jurisdiction,
17 true?

18 A Yes.

19 Q So if prescriptions increase, then
20 distributions increase, correct?

21 A Yes.

22 Q And by the same token, if prescriptions
23 written in a particular geographic location decrease,
24 then distributions to that geographic location will

1 typically decrease, true?

2 A Yes.

3 Q Can you point me to any study, academic
4 study, in which the authors found that opioid
5 prescribing increased because of a distributor's
6 shipments of opioids to pharmacies in a region?

7 MR. ARBITBLIT: Objection.

8 A I can't think of any study that answers
9 that specific question.

10 Q Well, have you conducted any -- have you
11 personally conducted any analysis to demonstrate a
12 causal relationship where opioid supply from
13 distributors to pharmacies in a specific region
14 causes more prescribing of opioids in that region?

15 MR. ARBITBLIT: Objection.

16 A Yes, I have.

17 Q What is your analysis? Can you point to me
18 a particular page or area of your report where you
19 conduct that analysis?

20 A So that analysis is the qualitative
21 research that I did for my book, showing how the
22 increased supply and increased access and increased
23 exposure to prescription opioids actually sped
24 demand.

1 Q Have you done any quantitative research to
2 demonstrate a relationship -- a causal relationship
3 between distributors' supply to a particular
4 geographic region and the prescribing practices of
5 doctors?

6 A I have not done my own quantitative
7 analysis. Except for -- sorry, except for a study of
8 Medicare Part D, which is only indirectly related to
9 your question.

10 Q And the study of Medicare Part D that you
11 refer to, is that included in your report?

12 A Yes.

13 Q And does it cover Cabell County and
14 Huntington, West Virginia?

15 A Yes.

16 Q And do you provide a confidence interval
17 that shows the relationship that you claim runs
18 between distribution of opioids and subsequent
19 prescribing?

20 MR. ARBITBLIT: Objection.

21 A No.

22 Q So we're on the same page, a confidence
23 interval, can you tell me what that is in an academic
24 paper?

1 A It's the likelihood that the finding is
2 reliable. It's a range of confidence that the value
3 found actually falls within that range.

4 Q And are you familiar with the term an
5 econometric analysis? Do you know what that is?

6 A Yes.

7 Q And an econometric analysis is an analysis
8 that tries to limit external variables so one can
9 track the impact of one particular action on the
10 outcome of a particular other variable. Is that a
11 fair description of econometric analysis?

12 MR. ARBITBLIT: Objection.

13 A I would qualify that a little bit to say
14 that in order to do that type of econometric
15 analysis, the economist has to sort of simulate the
16 universe, in which that event is occurring by trying
17 to determine all the different variables and what
18 might predict them, and then within that closed
19 system that they've created using their equations and
20 numbers, they try to prove various things.

21 So one of the major flaws of those types of
22 analyses is that that simulated universe doesn't
23 actually represent the real world.

24 Q Your analysis that you referred to a minute

1 ago of Medicare Part D data, was that an econometric
2 analysis or something else?

3 A No. That was not an econometric analysis.

4 Q During your testimony in the New York Frye
5 hearing about a week back, you talked about something
6 you described as a, quote, "feed forward cycle"
7 between opioid distributions and opioid prescribing.
8 Do you recall that?

9 A Yes, I do.

10 Q And you stated that as a result of the,
11 quote, feed forward cycle, the more opioids shipped
12 by a distributor, the more patients become dependent
13 on them, and then you said that doctors were then in
14 a position to have to continue to prescribe them.

15 Do you recall that testimony?

16 A Yes, I do.

17 Q Can you explain to me how it occurs that
18 doctors, quote, were in a position to have to
19 continue to prescribe opioids?

20 A Yes. And this is not a unique perspective.
21 This is a much discussed medical problem that we now
22 face. Having spent the last three decades putting
23 two or three generations of patients on opioids at
24 ever higher doses, we now have more than 10 million

1 Americans who are on opioids daily who cannot get
2 off. And when they try to stop them, they go into
3 serious, painful and even life-threatening
4 withdrawal.

5 So it is on the medical community now to
6 have to manage this population, which means that we
7 have to keep prescribing the opioids. We can't
8 abandon these opioid dependent patients that we have
9 created. And it presents a very difficult medical
10 situation, requiring a lot of resources to slowly
11 taper these patients down to safer doses or get them
12 off completely.

13 Doctors can't abandon these patients.
14 Often young physicians now are inheriting these
15 patients from doctors who are retiring, and they have
16 to keep prescribing the opioids, because given the
17 circumstance of an opioid dependent patient, it's the
18 only medically humane thing to do. But it doesn't
19 mean that they believe in the use of opioids for that
20 patient.

21 Q So let's talk about the root of the
22 feed-forward cycle you just described. There are
23 patients today who have been taking opioids for a
24 long period of time. Correct?

1 A Yes.

2 Q And the way those patients receive those
3 opioids is from a doctor's prescription, correct?

4 MR. ARBITBLIT: Objection.

5 A That is correct.

6 Q And it would be inhumane from a medical
7 perspective, I believe you just said, for doctors to
8 just cut those patients off and refuse to prescribe
9 them further opioids, correct?

10 A Yes. But doctors can subscribe to that
11 idea without believing that the opioids are helping
12 the patient. So it's what's called a harm reduction
13 strategy. Once they're already dependent, doctors
14 are now put in this difficult situation of having to
15 continue a treatment and then ameliorate a treatment
16 that's actually harming patients.

17 Q All very interesting, Doctor, but my
18 question was just the simple first step, okay, which
19 is that you agree that it would be inhumane of a
20 doctor, treating a patient who has been taking
21 opioids for many years to manage pain, to just cut
22 that patient off opioids; is that correct?

23 A Yes. That's correct. Although, it
24 wouldn't mean that the doctor should just continue

1 them indefinitely. The doctor needs to continue them
2 with a plan of getting them off.

3 Q The second part of your answer I'll move to
4 strike. Just answer the question that you're being
5 asked Doctor, okay? Mr. Arbitblit will have plenty
6 of time to ask you questions if he wants to.

7 Dr. Lembke, do you believe that when a
8 doctor prescribes opioids to a patient who's been on
9 them for many years, that a distributor should make
10 those medications available at pharmacies?

11 MR. ARBITBLIT: Objection.

12 A Again, so the frame of your question
13 doesn't encompass the scenario that I'm -- isn't
14 exclusive to the scenario that I'm talking about, so
15 which is why I can't answer it just yes or no. So
16 I'm happy to answer it --

17 Q --

18 A -- I'm happy to answer it, but I cannot
19 answer it yes or no.

20 Q Well, I think I can simplify it. When a
21 doctor makes a medical judgment to continue opioid
22 treatment for a patient because it is the humane
23 treatment option, should that patient be able to fill
24 that prescription?

1 MR. ARBITBLIT: Objection.

2 A Only if the doctor's decision-making was
3 informed by the evidence.

4 Q And the evidence, as you are referring to
5 there, would include an examination of the patient?

6 MR. ARBITBLIT: Objection.

7 A The evidence is largely the medical
8 literature and the public health crisis that we're
9 now facing called the opioid epidemic.

10 Q But, Doctor, in order to make a prescribing
11 decision for an individual patient, should the doctor
12 also examine the patient?

13 MR. ARBITBLIT: Objection.

14 A Yes.

15 Q And should the doctor talk to the patient?

16 A Yes.

17 Q And should the doctor learn the patient's
18 medical history?

19 A That should be part of the medical
20 decision-making, but again, the doctor cannot
21 exercise their clinical judgment based on that narrow
22 focus because most doctors have been duped about what
23 the appropriate action is.

24 Q Again, Doctor, not my question. My

1 question was simply: Should a doctor consider the
2 medical history of a patient in making a prescribing
3 decision? Yes or no.

4 A Yes, but I'm answering your question as it
5 follows from the other one, so I just want to make
6 sure I'm really answering what you're asking.

7 Q Dr. Lembke, earlier today you testified
8 that in your prescribing practices when you're
9 working with a patient and making a prescribing
10 decision related to opioids, approximately 50 percent
11 of the time you'll speak to the pharmacist involved
12 with that patient as well. Do you recall that
13 testimony?

14 A Yes.

15 Q Typically, do you speak to the pharmacist
16 before or after you've written the prescription in
17 that scenario?

18 A All of the above. I think the best way for
19 me to answer this question is to tell you that I have
20 frequent interactions with pharmacists about patients
21 that I have.

22 Q And in your practice, after you've
23 interacted with the pharmacist, does the ultimate
24 prescribing decision still rest with you as the

1 doctor?

2 A It does. I'm the one who signs the
3 prescription. But again, there are many factors that
4 influence that signing.

5 Q Tell me, Doctor, in your experience, what
6 are the types of information that you learn from
7 pharmacists when you call about a particular patient?

8 MR. ARBITBLIT: Objection.

9 A I will learn things like whether or not the
10 patient has seemed impaired when they've come to get
11 their prescription. I will learn things like whether
12 or not the patient is taking another medicine that
13 when combined with the medicine that I'm prescribing
14 could be dangerous. I will learn things like whether
15 or not the patient has a medication allergy that I
16 wasn't previously aware of, because maybe it's new or
17 maybe the patient forgot about it and didn't tell me
18 when I asked them about medication. I will learn
19 things like prior authorization and other third-party
20 payer issues that may come up.

21 So, you know, a lot. A lot of things are
22 mixed in that is exchanged in order to be able to
23 steward and monitor, you know, safe prescribing.

24 Q And you're comfortable sharing this

1 information with a pharmacist because a pharmacist is
2 part of the care that's provided to a patient as
3 well, correct? They're part of the chain of people
4 who help care for patients?

5 A Yes.

6 Q And can you share personal health
7 information with a pharmacist about a patient of
8 yours?

9 A No.

10 Q When you call a pharmacist, are you able to
11 give them the patient name?

12 A Yes.

13 Q Are you able to tell a pharmacist the
14 prescription that you have either written or are
15 considering writing for a particular patient?

16 A Yes.

17 Q Dr. Lembke, have you ever provided a
18 distributor, like one of the defendants here, the
19 name of one of your patients?

20 A No, but my understanding is that the
21 distributor defendants also function in part as
22 dispensers.

23 Q Dr. Lembke, I'm going to ask you to answer
24 my question. Have you personally ever provided the

1 name of one of your patients to a distributor,
2 Cardinal Health, McKesson, or AmerisourceBergen?

3 A No.

4 Q Have you ever provided any personal health
5 information about one of your patients to a
6 distributor?

7 A No.

8 Q Dr. Lembke, you just claimed that your
9 understanding is that distributors also function as
10 dispensers. By dispenser, do you mean as a pharmacy?

11 A Yes.

12 Q Dr. Lembke, you're aware that some
13 distributors also function as a pharmacy, for
14 example, CVS or Rite Aid or Walmart or Walgreens; is
15 that right?

16 A Yes.

17 Q And those distributors were in the New York
18 case, correct?

19 A Yes.

20 Q But they're not here in West Virginia -- in
21 this case, correct?

22 A No -- I mean, yes, that's correct. No,
23 they're not.

24 Q Dr. Lembke, are you aware of any of the

1 three distributor defendants in this case dispensing
2 opioids direct to a patient in Cabell County or
3 Huntington, West Virginia?

4 A I am aware of McKesson collaborating with
5 Janssen to dispense Nucynta, using coupons. So in
6 that sense, yes, I am aware of one of the defendants
7 in this case working very closely with pharmacies to
8 provide patients with discounts on opioids.

9 Q We'll return to McKesson in a second. As
10 for AmerisourceBergen and Cardinal Health, are you
11 aware of either AmerisourceBergen or Cardinal Health
12 dispensing opioids in Cabell County or Huntington,
13 West Virginia?

14 A I'm just going to look at my report so that
15 I can answer this.

16 Q Well, sitting here today, without looking
17 at your report, can you answer my question? Do you
18 know the answer?

19 MR. ARBITBLIT: You're entitled to
20 look at your report.

21 A Yeah, I think I know the answer, but I
22 would really like to make sure that I get it right.
23 So I would like to take a moment to look at my
24 report.

1 MR. PYSER: All right. Let's go off
2 the record. You can look at your report.

3 MR. ARBITBLIT: Stay on the record.
4 She has a right of a reasonable time to look at the
5 report. We're on the record.

6 MR. PYSER: We'll see how long we take
7 here.

8 MR. ARBITBLIT: It won't be long,
9 Steve.

10 THE DEPONENT: Okay. I'm ready.

11 MR. PYSER: Madam Court Reporter, can
12 you read back the question? It might not have been
13 the immediate last question. I think it was one
14 prior.

15 (The reporter read back the following
16 as requested: "QUESTION. We'll return to McKesson in
17 a second. As for AmerisourceBergen and Cardinal
18 Health, are you aware of either AmerisourceBergen or
19 Cardinal Health dispensing opioids in Cabell County or
20 Huntington, West Virginia?)

21 A So, I am aware of campaigns involving
22 Cardinal Health and AmerisourceBergen to promote
23 opioids at the pharmacy, and that is related to
24 dispensing, because it drives demand.

1 Q Dr. Lembke, that was not even close to my
2 question. My question was about dispensing. Are we
3 agreed that dispensing is what a pharmacist does when
4 a pharmacist dispenses a medication to a patient,
5 correct?

6 A Yes.

7 Q Are you aware of any dispensing by Cardinal
8 Health or AmerisourceBergen in Cabell County or
9 Huntington, West Virginia?

10 A Not Cardinal Health or AmerisourceBergen,
11 no.

12 Q Okay. Now, as to McKesson Corporation, are
13 you aware of McKesson Corporation dispensing an
14 opioid to a patient in the role of a pharmacist in
15 Cabell County or Huntington, West Virginia?

16 A Yes, I believe so.

17 Q And what pharmacy do you believe McKesson
18 dispenses that in Cabell County or Huntington,
19 West Virginia?

20 A So I'm speaking of McKesson's pharmacy
21 intervention program more broadly.

22 Q And do you know whether that's present in
23 Cabell County?

24 A I assume that it is, since it's a national

1 campaign.

2 Q Can you name a pharmacy where that program
3 occurs in Cabell County?

4 A No.

5 Q You mentioned earlier today in one of your
6 responses something called The Joint Commission.
7 What is The Joint Commission?

8 A The Joint Commission is an accreditation
9 body that gives hospitals a kind of seal of approval
10 based on whether or not they're meeting certain
11 quality measures. And it carries considerable weight
12 in the medical community.

13 Q And are you aware of any relationship
14 between The Joint Commission and the Distributor
15 Defendants here?

16 A No.

17 Q Dr. Lembke, are you aware that the City of
18 Huntington sued The Joint Commission?

19 A No.

20 Q You've never seen a copy of that complaint
21 filed by the City of Huntington?

22 A Not that I'm recalling.

23 Q Okay. Unfortunately, we didn't get that
24 one into the box. So we're going to show you

1 Exhibit 32.

2 MR. PYSER: Brad, do you have the
3 ability to put that on the screen?

4 MR. MASTERS: Yes, one second.

5 MR. ARBITBLIT: I'm just going to
6 register an objection to introducing documents that
7 weren't provided. I don't think that's pursuant to
8 the protocol of the Court. I object to any testimony
9 on the exhibit as well.

10 MR. PYSER: While we're getting that
11 up -- oh, here we go. Brad, if you could go to
12 paragraph 32 -- excuse me, paragraph 8.

13 MR. ARBITBLIT: Counsel, can you just
14 acknowledge a standing objection to questions on a
15 document that wasn't produced so I don't have to
16 object to every question?

17 MR. PYSER: Sure.

18 THE DEPONENT: Can you make it a
19 little bigger, too, with that plus sign?

20 Great, thanks.

21 BY MR. PYSER:

22 Q Paragraph 8 of this complaint filed by the
23 City of Huntington says: "JCAHO," which stands for
24 The Joint Commission, "enforcement of its pain

1 management standard and JCR's widespread
2 misinformation campaign about the safety of opioids
3 has also led to an overprescribing of opioids, not
4 only in terms of doses and necessity, but also in
5 terms of quantity."

6 Do you agree with that statement?

7 A Yes, I do.

8 Q If you go to paragraph 52 on page 16, says:

9 "The Joint Commission's pain management
10 standards provided opioid manufacturers with a golden
11 opportunity to promote their products, seizing on
12 this opportunity with particular vigor was Purdue,
13 the manufacturer of OxyContin."

14 Do you agree with that statement?

15 A Yes, I do.

16 Q All right. Let's go to paragraph 68.

17 "The Joint Commission's endorsement and
18 promotion of the free-of-pain goal contributed not
19 only to the widespread prescription of opioids, but
20 also to opioid doses strong enough to deliver freedom
21 from pain."

22 Do you agree with that statement?

23 A Yes, I do.

24 Q And if we go to paragraph 80. The Joint

1 Commission -- excuse me. Strike that.

2 If we go to paragraph 80: "The Joint
3 Commission's enforcement of the pain management
4 standards has also been reckless and negligent. To
5 this day, despite the mountain of evidence
6 demonstrating the dangers of opioids, The Joint
7 Commission continues to emphasize the zealous and
8 aggressive identification and management of pain in
9 prescribing of opioids as a solution."

10 Do you agree with that statement?

11 A Well, when was this written? Because the
12 "to this day" --

13 MR. PYSER: Sure.

14 Brad, if you go to the signature page,
15 it should have a date on it -- or the first page
16 actually does as well.

17 Q This is filed on November 2nd, 2017.

18 A Yes, I agree with that statement.

19 Q And if we go to paragraph 89, do you agree
20 with the claim by the City of Huntington that, quote:

21 "Because of the Joint Commission's conduct,
22 the municipalities have suffered significant and
23 ongoing harm." Do you agree with that?

24 A Yes, I do.

1 Q Let's go to page 83 of Exhibit 1, your
2 report. And if you look at the bottom of page 83,
3 there is No. 7. That's your seventh opinion. Do you
4 see that, in bold?

5 A Yes.

6 Q And you wrote that:

7 "The pharmaceutical opioid industry
8 misrepresented that the risk of addiction to
9 prescription opioids is rare or less than 1 percent,
10 when, in fact, prescription opioids are as addictive
11 as heroin and the risk of addiction is far higher
12 than that stated by the industry. The best
13 conservative data show an opioid addiction prevalence
14 of 10 to 30 percent among chronic pain patients
15 prescribed opioids."

16 Do you see that statement?

17 A Yes, I do.

18 Q And there, when you're talking about the
19 pharmaceutical opioid industry misrepresenting the
20 risk of addiction, you're talking about opioid
21 manufacturers, correct?

22 A I'm talking about primarily opioid
23 manufacturers, but distributors also played a role.

24 Q Okay. Can you point me to a statement by a

1 distributor in which a distributor stated that
2 addiction to prescription opioids is rare or less
3 than 1 percent?

4 A Well, I can point you to a statement and
5 document that distributors were involved in
6 disseminating to providers and patients that
7 communicated that, yes.

8 Q Okay. So just to be clear what we're
9 talking about, the statements that you're referring
10 to are statements of manufacturers that you claim
11 were communicated through distributors, correct?

12 A That distributors either through
13 distributors or facilitated by a partnership between
14 manufacturers and distributors.

15 Q Can you point me to a statement by someone
16 who works for a distributor that the risk of
17 addiction to prescription opioids is rare or less
18 than 1 percent?

19 A I can point you to statements by
20 individuals who work for distributors which clearly
21 communicated that those individuals understood that
22 opioids are highly addictive and illegal.

23 Q Is that a statement in your report?

24 A Yes.

1 Q Under paragraph 7? Can you point me to
2 that?

3 A Under paragraph 7?

4 Q I'm sorry. Opinion 7 on page 83.

5 A Well, I'll find where it is and then I'll
6 tell you where it is. How about that?

7 Okay. So on page 94. On July 2nd,
8 2012 -- well, first of all, starting on page 93.

9 "On April 22, 2011, Joseph Tomkiewicz,
10 Corporate Investigator at AmerisourceBergen, sent an
11 email to colleagues under the subject, 'Saw This and
12 Had to Share It.' It was a parody written to the
13 tune of Beverly Hillbillies. 'Come and listen to a
14 story about a man named Jed, a poor mountaineer,
15 barely kept his habit fed...Said sunny Florida is the
16 place you ought to be, so they loaded up the truck
17 and they drove speedily, South, that is, Pain
18 Clinics, cash-and-carry, a Bevy of Pillbillies, Pill
19 Mills, that is buy some, take a load home.'"

20 Q Dr. Lembke, I see where you're reading on
21 page 93, item (g)(1). Dr. Lembke, that email was not
22 sent outside AmerisourceBergen, was it?

23 A Well, no, but I think in answer to your
24 question, that is -- I did have an accurate response

1 to your specific question. You asked me if anybody
2 who worked for the Distributor Defendants.

3 Q Okay.

4 A Yeah.

5 Q Did anyone who worked for a distributor
6 defendant communicate to a doctor or pharmacist that
7 the risk of addiction to prescription opioids is rare
8 or less than 1 percent?

9 A Yes.

10 Q And where are you getting that answer from?

11 A This is in the additional material that I
12 reviewed yesterday.

13 Q Okay. And what particular document that
14 you reviewed yesterday showed that?

15 A It was another expert witness's report on
16 AmerisourceBergen -- I believe it was
17 AmerisourceBergen, creating an educational series to
18 combat, quote/unquote, opioid phobia, opioid phobia
19 being the idea that doctors are afraid to prescribe
20 opioids when they shouldn't be.

21 Q And other than that expert report by
22 another expert you reviewed yesterday, are you aware
23 of any other instance in which a distributor,
24 Cardinal Health, AmerisourceBergen, or McKesson

1 Corporation, communicated to a doctor or a pharmacist
2 that the risk of addiction to prescription opioids is
3 rare or less than 1 percent?

4 A Yes, in the pharmacy intervention program.

5 Q That's McKesson?

6 A Yes.

7 Q That's the McKesson program?

8 A Yes.

9 Q And do you speak of the pharmacy
10 intervention program in your report?

11 A Yes, I do.

12 Q Okay. How about for Cardinal Health? Are
13 you aware of any Cardinal Health employee informing a
14 doctor or a pharmacist that the risk of addiction to
15 prescription opioids is rare or less than 1 percent?

16 A Yes. So on page 57 of my report, Cardinal
17 Health partnered with Teva to promote Teva products,
18 and they distributed 105,000 email communications to
19 retail pharmacists. And that --

20 Q Dr. Lembke, I typically --

21 -- hold on. I typically don't stop
22 you, but you're actually not reading your report
23 correctly.

24 A Okay.

1 Q What page 57 states is that:

2 Cardinal Health agreed to distribute at
3 Teva's request one email communication to 105,000
4 retail pharmacists.

5 Do you see that?

6 A Yes. I'm sorry. You're right. Thank you
7 for the correction.

8 MR. ARBITBLIT: I apologize. My
9 mistake.

10 THE DEPONENT: I just wanted to say
11 that, "The content stated," quote, "may include
12 product benefits, ordering information, and website
13 links."

14 I think that's important, because in
15 my review of these communications within the pharmacy
16 intervention program that risks including --
17 especially the risk of opioid addiction, is left out.
18 So I think those are serious errors of omission.

19 BY MR. PYSER:

20 Q And it's your position that in the
21 materials you reviewed, there is not information
22 about the risks of opioids?

23 A There's information about the risks, but
24 specifically the pharmacists are not coached to

1 convey information about the risks of addiction in my
2 review of documents. In fact, they're coached to
3 emphasize the benefits and encourage adherence to
4 take higher doses.

5 Q You said that pharmacists are coached. Who
6 are you alleging coached pharmacists?

7 A McKesson's pharmacy intervention program is
8 a whole program designed to coach pharmacists on how
9 to talk to patients when they come to get their
10 medication in order to promote sales.

11 Q Are you making any allegation of such
12 coaching of pharmacists by AmerisourceBergen?

13 A No.

14 Q How about Cardinal Health?

15 A Not that I'm aware of.

16 Q On Appendix I of your report, and let me
17 try to find that page for you, Dr. Lembke. That's at
18 page 183 of Exhibit 1.

19 A Yes.

20 Q Okay. And Appendix I, if you just look at
21 the title, is called "Misleading Promotional
22 Messages," correct?

23 A Yes.

24 Q Okay. And you list five companies there?

1 A Yes.

2 Q Purdue Pharma, Teva/Cephalon, Janssen, Endo
3 and Allergan?

4 A Yes.

5 Q To your knowledge, none of those companies
6 are defendants in this particular litigation in
7 West Virginia, correct?

8 A That is correct.

9 Q Can you identify any false or misleading
10 claim about the safety and efficacy of opioids by one
11 of the Distributor Defendants here to a doctor in
12 West Virginia, Cabell or Huntington County?

13 A As in my report, I understand that there
14 were national -- are national campaigns wherein the
15 distributor defendants collaborated with the
16 manufacturers and in that process promoted and
17 disseminated those misleading messages. So they were
18 party to that.

19 Q Can you name for me a single doctor in
20 Cabell County or Huntington who received from a
21 distributor defendant one of these messages you claim
22 is misleading?

23 A No.

24 Q Dr. Lembke, do you believe that the FDA

1 approved labels for opioids were misleading?

2 MR. ARBITBLIT: Objection.

3 A Yes.

4 Q Which ones?

5 MR. ARBITBLIT: Objection.

6 A Well, I believe that the FDA label didn't
7 adequately communicate the degree of risk of
8 addiction. And, in general, also, you know, endorsed
9 the use of opioids in the treatment of chronic pain
10 without evidence to support it.

11 Q Are you familiar with the labeling process
12 that a manufacturer goes through before they can sell
13 a medicine, such as an opioid?

14 A I'm broadly familiar with the process. I
15 know it's a complex, multistage process. I'm not
16 familiar with the specifics.

17 Q Are you familiar with the fact that the
18 manufacturer interacts directly with the FDA to gain
19 approval of a label before a medication can be sold
20 in the United States?

21 A Yes, I am aware of that.

22 Q Are you aware of any role by the
23 Distributor Defendants in the FDA approval process
24 for labels of opioids in the United States?

1 A No.

2 Q Dr. Lembke, you have reviewed hundreds,
3 probably thousands of pages of opioid related
4 promotional materials; is that right?

5 A Yes.

6 Q Fair to say that the vast, vast majority of
7 that material was written and promulgated by opioid
8 manufacturers?

9 A Yes.

10 Q And it's your opinion that those
11 promotional messages from opioid manufacturers
12 contained many misleading or false statements about
13 safety and efficacy of opioids; is that right?

14 A Yes.

15 Q And is it your opinion that opioid
16 manufacturers created those misleading marketing
17 materials to sell more of their products?

18 A Yes.

19 Q And is your opinion that the opioid
20 manufacturers were wildly successful in duping
21 doctors into prescribing large quantities of opioids
22 to patients?

23 A Yes.

24 Q And, in fact, earlier in your career, you

1 were duped into prescribing opioids by opioid
2 manufacturers, correct?

3 A Yes.

4 Q Were your actions, when you prescribed
5 opioids, evil? Did you intend to harm patients?

6 A No.

7 Q Do you think that the opioid manufacturers
8 intended to harm patients?

9 MR. ARBITBLIT: Objection.

10 A I think -- I believe there was a willful
11 disregard of patients in their actions.

12 Q By the opioid manufacturers?

13 A Yes.

14 MR. ARBITBLIT: Objection.

15 THE DEPONENT: And distributors.

16 Q What's the basis for your claim that
17 distributors acted with willful disregard of
18 patients?

19 A They pumped billions of pills all over the
20 United States, without taking into consideration the
21 public health crisis that would ensue, even though
22 they had access to the information that everybody
23 else had access to. I believe they were profit
24 driven with -- and disregarding patient's safety.

1 Q Did you have access to information when you
2 were a doctor after graduating from Stanford?

3 MR. ARBITBLIT: Objection.

4 A I'm sorry, access to what information?

5 Q Information about the safety and efficacy
6 of opioids.

7 MR. ARBITBLIT: Objection.

8 A Can you rephrase the question? I'm not
9 sure I'm understanding it.

10 Q At the time in your career when you were
11 prescribing opioids and you stated earlier you were
12 duped, did you have access to information about the
13 safety and efficacy of opioids?

14 MR. ARBITBLIT: Objection.

15 A Well, I was a medical student and I was a
16 resident, and I didn't really have access to that
17 information, no.

18 Q Okay. Do you believe -- Did you do your
19 residency at Stanford, Doctor?

20 A Yes.

21 Q So as a resident at Stanford, you had
22 already had four years of medical school, correct?

23 A Yes.

24 Q And you had access at the time to attending

1 physicians?

2 A Yes, I did.

3 Q And you could ask questions?

4 A Yes.

5 Q Dr. Lembke, is there any requirement that
6 you're aware of by the DEA or state regulatory bodies
7 that distributors of medication have people on staff
8 who have gone to medical school?

9 A I don't know about any requirements. I
10 would hope they have some people on staff who have
11 gone to medical school, but I don't know.

12 Q Dr. Lembke, are you aware of any
13 requirement by the DEA or state regulatory agencies
14 that distributors are required to have people on
15 staff with the same medical training that you have?

16 MR. ARBITBLIT: Objection.

17 A I'm not aware of the requirements of
18 distributors' staff, no.

19 Q Is it possible that if you, a Stanford
20 trained physician, were duped by marketing messages
21 that convinced you that opioid prescription was
22 appropriate care, that distributors also believed the
23 same message at the time, that opioids were
24 appropriate medical care?

1 MR. ARBITBLIT: Objection.

2 A I think the difference is that I, you know,
3 was trying to eke out a living, and I wasn't making
4 the massive profits of having the huge impact as an
5 individual prescriber. I think the distributors had
6 a much bigger responsibility.

7 Q Dr. Lembke, is it possible that the
8 distributors understood the standard of care to be
9 the same as you understood it to be at the time you
10 testified you were duped by manufacturer marketing?

11 MR. ARBITBLIT: Objection.

12 A It's hard for me to imagine that
13 distributors were duped when they had access to the
14 whole picture, what was happening across the whole
15 country, in terms of shipping their pills.

16 Q I'm not asking about shipping their pills.
17 I'm asking about the standard of care. So is it
18 possible that distributors' understanding of the
19 standard of care was the same as yours, a Stanford
20 trained doctor?

21 MR. ARBITBLIT: Objection.

22 A I do not believe the distributors were
23 duped.

24 Q Is it possible that the distributors'

1 understanding of the standard of care was the same as
2 yours, a Stanford trained doctor?

3 A I do not believe the distributors'
4 understanding of the standard of care was the same as
5 mine, a Stanford doctor.

6 Q So, Dr. Lembke, do you believe the
7 distributors knew more about the standard of care
8 than you, a Stanford trained physician?

9 MR. ARBITBLIT: Objection.

10 A I think the distributors had access to data
11 about the opioid epidemic that I could not have seen
12 as an individual clinician.

13 Q Again, I'm talking strictly about the
14 standard of care, Doctor. Do you believe the
15 distributors had access to the same information you
16 did about the standard of care, you, a Stanford
17 trained physician?

18 MR. ARBITBLIT: Objection. Asked and
19 answered. Vague.

20 A I think I answered it. I don't really have
21 another answer.

22 Q Please answer the question.

23 MR. ARBITBLIT: Asked and answered.

24 MR. PYSER: You can answer.

1 A I feel like I've given you my answer.

2 Q Well, give me the answer then, Dr. Lembke.
3 What is the answer?

4 MR. ARBITBLIT: If you have anything
5 further to add, you may. If you don't, you don't
6 have to.

7 MR. PYSER: Dr. Lembke --

8 Your objection is noted, Counsel --
9 Counselor, your objection is noted. If the Court
10 agrees with your objection to form, so be it. But
11 she still has to answer the question.

12 BY MR. PYSER:

13 Q Dr. Lembke, please answer the question.

14 A So the way you phrased the question makes
15 me -- makes it difficult for me to answer
16 differently. You know, as I said before, standard of
17 care is not a term that doctors -- that's not our
18 language, that's language that lawyers use.

19 If you could carefully define standard of
20 care for me, then, you know -- or use different
21 language than that, maybe I could try to answer it
22 again.

23 Q Dr. Lembke, do you believe the Distributor
24 Defendants in this case had access to the same

1 information that you had about appropriate medical
2 treatment?

3 A I believe they had access to more
4 information than I had.

5 MR. ARBITBLIT: Objection.

6 Q So it's your position that Distributor
7 Defendants have more information about medical care
8 than a Stanford trained physician, correct?

9 MR. ARBITBLIT: Objection.

10 A They had more information about opioid
11 prescribing than I did.

12 Q Not asking -- Dr. Lembke, we're going
13 around in circles. I'm not asking about prescribing.
14 I'm asking about medical practice. Sometimes it's
15 called standard of care, sometimes best practices.

16 Dr. Lembke, I'm asking: Did the
17 Distributor Defendants have access to the same
18 information about patient treatment that you, a
19 Stanford trained physician, had access to?

20 MR. ARBITBLIT: Objection. Asked and
21 answered. Badgering the witness.

22 A Yeah, so I feel like you have now changed
23 the question. You know, the original question was --
24 I mean, really --

1 -- CROSSTALK --

2 MR. ARBITBLIT: Don't interrupt her.
3 Don't interrupt her. She's answering. You can make
4 your point when she is done, not in the middle of her
5 statement.

6 MR. PYSER: Doctor, if you feel that I
7 have changed the question, that's fine. Answer the
8 question that was just asked instead of just talking
9 about things that have nothing to do with the
10 question.

11 Madam Court Reporter, can you read
12 back the question that Dr. Lembke just acknowledged
13 is a new question.

14 And Dr. Lembke, can you please answer
15 the question.

16 (The reporter read back the following
17 as requested: "Question: Dr. Lembke, we're going
18 around in circles. I'm not asking about prescribing.
19 I'm asking about medical practice. Sometimes it's
20 called standard of care, sometimes best practices.

21 Dr. Lembke, I'm asking: Did the
22 Distributor Defendants have access to the same
23 information about patient treatment that you, a
24 Stanford trained physician, had access to?"

1 MR. ARBITBLIT: Objection. Asked and
2 answered. Object to the prelude to the question.
3 That wasn't a question. Fifty percent of what was
4 just read is counsel's statement rather than a
5 question.

6 If you have anything to add to
7 previous answers, you may do so.

8 THE DEPONENT: Well, I really, really
9 believe I answered that. I really did answer that.
10 And it's in the record.

11 MR. PYSER: Madam Court Reporter, can
12 you please read just the question. Per counsel's
13 request, we'll strike the prelude. Just the
14 question.

15 And Dr. Lembke, I'm going to ask you,
16 please answer the question.

17 (The reporter read back the following
18 as requested: "Did the Distributor Defendants have
19 access to the same information about patient treatment
20 that you, a Stanford trained physician, had access
21 to?")

22 MR. ARBITBLIT: That has been asked
23 and answered multiple times.

24 THE DEPONENT: My answer -- again, my

1 answer is not going to change.

2 BY MR. PYSER:

3 Q Go ahead and answer the question that was
4 asked, please.

5 A I believe the Distributor Defendants had
6 access to more information than I had.

7 Q And that additional information is the
8 distributions of the distributors, correct?

9 A That's right. The number of pills going
10 into all different geographic regions, which
11 pharmacies, you know, alerts on possible diversion.
12 They had the 30,000-foot view that I could never
13 have.

14 Q Dr. Lembke, are you aware that the
15 distributors report all of their distributions to the
16 DEA?

17 MR. ARBITBLIT: Objection.

18 A Okay. Yes.

19 Q Dr. Lembke, are you aware of any medical
20 literature that was hidden from you as a Stanford
21 educated physician, but was made available to
22 Distributor Defendants?

23 MR. ARBITBLIT: Objection.

24 A It's not a matter of it being hidden. It's

1 a matter of what I, as a clinician, need to spend my
2 time on and focus on and what are the greatest
3 influences on my decision-making. And I've written
4 at length about what those influences are, and they
5 are things like pads and pens presented by sales
6 reps; CME where, you know, the benefits are
7 overstated and the risks are understated; what the
8 pharmacist tells me; the pharmacist's interaction
9 with my patients; my patient bringing in a coupon
10 card and saying will you prescribe this for me
11 because I get a rebate.

12 So there are lots of influences, as I've
13 talked about.

14 Q Dr. Lembke, are you aware of any pads or
15 pens provided by the Distributor Defendants to
16 doctors encouraging opioid prescribing?

17 A No.

18 Q Dr. Lembke, are you aware of any CME
19 courses sponsored by the Distributor Defendants
20 talking about opioid prescribing?

21 A Yes.

22 Q What is the CME course you claim to be
23 aware of sponsored by a distributor defendant?

24 A This is material that I reviewed recently

1 showing that, I believe, McKesson hired Aselsa, which
2 was a separate institution or company that was --
3 retained by distributors to promote opioid sales.

4 Q What -- I apologize, Dr. Lembke. If that
5 was on the list of materials that was provided last
6 night, we have not had a chance to look at it. That
7 was a -- you're claiming there's a McKesson program
8 that sponsored CMEs about opioids?

9 A I can't remember if it was
10 AmerisourceBergen or Cardinal or McKesson, but I
11 remember reading about doing focus groups with
12 patients, doing CME for providers.

13 Q Is that discussed in your report or that's
14 something you learned about after your report?

15 A That's something I learned about after my
16 report.

17 Q And you haven't supplemented your report to
18 describe that in any way, shape, or form, have you?

19 A No.

20 Q What is the Federation of State Medical
21 Boards?

22 A It's an organization that oversees state
23 medical boards. State medical boards are entrusted
24 with ensuring that doctors are practicing in a safe

1 way and sanctioning them. If they are not practicing
2 safely, state boards can produce guidelines and
3 quality standards.

4 Q Was the Federation of State Medical Boards,
5 the FSMB, were they duped by the manufacturers?

6 A Yes. I believe so.

7 Q Are you aware of any communications between
8 Distributor Defendants and the Federation of State
9 Medical Boards?

10 A No.

11 Q How about Stanford Medical School? Was
12 Stanford Medical School duped by the manufacturers?

13 MR. ARBITBLIT: Objection.

14 A Yes.

15 Q And are you aware of any communications
16 between the Distributor Defendants and Stanford
17 Medical School?

18 A No.

19 Q How about the FDA? Was the FDA duped by
20 the manufacturers?

21 A Yes, I believe so.

22 Q And are you aware of any communications
23 about opioids between the distributors and the FDA?

24 A No.

1 Q How about the DEA? Was the DEA duped by
2 the manufacturers?

3 A Yes.

4 Q And are you aware of any communications
5 between the distributors and the DEA about
6 appropriate prescribing of opioids?

7 A No.

8 Q How about the World Health Organization?
9 Was the World Health Organization duped by
10 manufacturers?

11 A Yes.

12 Q And are you aware of any communications
13 between distributors and the World Health
14 Organization about appropriate prescribing of
15 opioids?

16 A No.

17 Q You're aware that many states across the
18 country issued reports in the 1990s and into the
19 2000s recommending what was described as removal of
20 barriers to the treatment of pain?

21 A Yes.

22 Q And by removal of barriers to the treatment
23 of pain, that means, in part, making opioids more
24 available to patients, correct?

1 A Yes.

2 Q And among the states where barriers to
3 treatment of pain were removed, included New York?
4 Correct?

5 A Yes.

6 Q West Virginia?

7 A Yes.

8 Q And were those states that acted to remove
9 barriers to using controlled substances for the
10 treatment of pain, were they duped by the
11 manufacturers?

12 A Yes.

13 Q Are you aware of any communications between
14 distributors and the State of West Virginia about
15 removing barriers to using controlled substances for
16 the treatment of pain?

17 A Can I check my report? There is one thing
18 I want to look at to answer that.

19 Q Sure. Go ahead.

20 A Won't take me very long.

21 MR. ARBITBLIT: While she's doing
22 that, Steve, can you say when you might want to take
23 that 15, 20-minute, half an hour, whatever you need
24 for lunch break?

1 MR. PYSER: Yeah, we can do it soon.
2 I don't know, Don, if you're on the West Coast or
3 East Coast, but I'm guessing my East Coast friends
4 would appreciate --

5 MR. ARBITBLIT: -- I don't need much
6 of a break. I'm on the witness's schedule, as far as
7 getting her done in the time frame she would like.
8 So if your team is willing to have a short lunch,
9 we'd be fine with that.

10 A My answer is no.

11 MR. PYSER: Madam Court Reporter,
12 there was a lot of lunch talk in between that. Can
13 you just read back the question so we make sure we
14 have --

15 (The reporter read back the following
16 as requested: "Are you aware of any communications
17 between distributors and the State of West Virginia
18 about removing barriers to using controlled substances
19 for the treatment of pain?")

20 BY MR. PYSER:

21 Q And your answer, Dr. Lembke?

22 A It was: No.

23 Q How about the American Medical Association,
24 was the American Medical Association duped by the

1 manufacturers?

2 A I'm not aware of any communications between
3 the American Medical Association and -- oh, sorry,
4 yes.

5 Q Okay. Let's --

6 A I was jumping ahead to your next question.

7 Q So let's strike that last one, because I
8 think it was pretty confusing, and I'll ask it again.
9 Was the American Medical Association duped by the
10 manufacturers about the treatment of pain through
11 opioids?

12 A Yes.

13 Q And are you aware of any communications
14 between distributors and the American Medical
15 Association about the treatment of pain and use of
16 opioids?

17 A No.

18 MR. PYSER: Okay. Why don't we take
19 that lunch break now. We can go off the record.

20 VIDEOGRAPHER: The time is 1:26.
21 We're now going off the record.

22 (A recess was taken.)

23 VIDEOGRAPHER: The time is 2:05.
24 We're now back on the record.

1 BY MR. PYSER:

2 Q Welcome back, Dr. Lembke. You understand
3 you're still under oath, correct?

4 A Yes.

5 Q All right. Dr. Lembke, I want to return
6 briefly to your experience and a particular category
7 that I want to ask you about. Do you have a degree
8 in marketing?

9 A No.

10 Q Have you published any studies on the
11 impact of marketing?

12 A Yes.

13 Q What are the studies you've published that
14 concern the impact of marketing?

15 A That would be my book, Drug Dealer, M.D.

16 Q Is your book peer reviewed?

17 A Yes.

18 Q Okay. And it was peer reviewed in the same
19 way an article would have been published if, let's
20 say, you published in the New England Journal of
21 Medicine?

22 A Similar.

23 Q Okay. But your book wasn't published in a
24 journal, it was published by a publishing company,

1 correct?

2 A By an academic publishing house. Johns
3 Hopkins University Press.

4 Q In addition to your book, have you
5 published any other materials on marketing and the
6 impact of marketing on doctor prescribing?

7 A No.

8 Q Do you teach any classes at Stanford on
9 marketing?

10 A As pertains to the opioid epidemic, yes.

11 Q Anything beyond the opioid epidemic?

12 A No.

13 Q And when you say you teach a class on
14 marketing as it pertains to the opioid epidemic, is
15 that a stand-alone class or is it one day of class
16 within a larger curriculum?

17 A It's within a larger curriculum.

18 Q And do you hold yourself out in the medical
19 community as an expert on marketing?

20 A To some extent, yes.

21 Q And is that limited to the impact of
22 marketing on the opioid epidemic?

23 A Yes.

24 Q And are you aware if your book has been

1 cited by any experts in marketing as an authoritative
2 document about marketing and the impact of marketing
3 on opioid medications?

4 A It has been cited, but I can't remember --
5 I can't name the specific article.

6 Q Do you know how many times it's been cited?

7 A No.

8 Q Prior to looking at marketing in your book,
9 did you take any marketing classes?

10 A No.

11 Q So I want to look at an opinion you have in
12 your report, Exhibit 1 at page 8. It's Opinion
13 No. 5.

14 Are you with me, Doctor?

15 A Yes.

16 Q And this opinion claims that: "Opioid
17 distributors collaborated with opioid manufacturers
18 and pharmacies to promote sales of opioid pain
19 pills," correct?

20 A Yes.

21 Q This opinion, Opinion No. 5, did not appear
22 in your two previous reports, the Ohio Federal Report
23 or the New York Litigation Report, did it?

24 A No, it did not.

1 Q Did you form this opinion sometime after
2 you submitted your New York report?

3 A No, but I was able to provide more detail
4 about this opinion than I already had.

5 Q In the prior reports, you had talked about
6 promotion of opioid pain pills by manufacturers,
7 correct?

8 A Yes.

9 Q And in your report now, where you've added
10 this opinion, did you include in your report the
11 materials and references you relied on to form your
12 opinion, Opinion No. 5?

13 A Yes.

14 Q I'd like to ask you some questions in
15 particular about how this opinion relates to my
16 client, Cardinal Health. And the other distributors
17 might ask some specific questions later on today
18 about their clients.

19 So I'm going to take you first in Exhibit 1
20 to page 57, and at Item (c)(3) -- excuse me, yeah,
21 (c)(3), you state that: "Cardinal Health partnered
22 with Teva to promote Teva products."

23 Do you see that?

24 A Yes.

1 Q Now, I want to go beyond your citations to
2 the actual documents that you're purporting to
3 examine here, okay?

4 A Okay.

5 Q So let's take a look, if you could -- this
6 is going to be Exhibit 7. It's going to be in the
7 box.

8 Do you have Exhibit 7 now?

9 A Yes, I do.

10 Q It's a two-page document, correct? And
11 it's got the same Bates number as that cited in
12 footnote 173, 174, and 175 of your report, correct?

13 A Yes.

14 Q Okay. And this is the only document you
15 cite to support what you say in roman numerette iii
16 on page 57, correct?

17 A That's right.

18 Q Okay. So as to this supposed partnership,
19 this document, Exhibit 7, is a Marketing Contract
20 Review/Signoff, correct?

21 MR. ARBITBLIT: Object to form.
22 Argumentative.

23 A Yes, that's what it says at the top,
24 uh-huh.

1 Q Okay. And it describes the scope of the
2 project as being, quote, "E-Blast to reach 105,000
3 pharmacists with key info at launch, stocking NDC
4 numbers," et cetera. Do you see that?

5 A Yes.

6 Q Okay. And the total dollar amount spent
7 here is \$18,000. That's in the third line, right?

8 A Yes.

9 Q Okay. Have you ever seen the invoice for
10 \$18,000, to show that this was actually consummated
11 and done?

12 A No.

13 Q And, in fact, if you turn to the next page,
14 in the third paragraph it reads, quote:

15 "Notwithstanding the foregoing, Teva is under no
16 obligation to request that any communication be
17 distributed, and Cardinal Health will only invoice
18 Teva once a requested communication is actually
19 distributed by Cardinal Health."

20 Did I read that correctly?

21 A Yes.

22 Q Okay. And you don't cite in your report
23 any actual document promoting a Teva product
24 distributed by Cardinal Health pursuant to this

1 agreement, do you?

2 A No.

3 Q And you're not aware of any pharmacist in
4 Cabell County or the City of Huntington who received
5 marketing material from Cardinal Health or Teva
6 pursuant to this agreement, are you?

7 A No.

8 Q Let's look at the next claimed marketing
9 document related to Cardinal Health. On page 57, the
10 next item you say is: "Cardinal Health partnered
11 with Actavis to promote Kadian."

12 Do you see that?

13 A Yes.

14 Q And there's a footnote to that single note.
15 It's at footnote 176. Do you see that?

16 A Yes, I do.

17 Q Are you aware of any documents other than
18 that footnote to support your opinion on page 57 in
19 roman numerette No. 4?

20 A No, except that I will just add that I'm
21 looking at all of these documents in aggregate to
22 support my conclusions that the distributors were
23 more than, quote/unquote, just the trucks.

24 Q We're going to go through each of the

1 Cardinal Health documents that you cite. I'm going
2 to ask you to open up, if you could, Exhibit 9.

3 And this is an email communication between
4 Cardinal Health and employees of Actavis about a
5 medication called Kadian, correct?

6 A Uh-huh. Yes.

7 Q And are you aware of any false statements
8 in the Kadian campaign that was part of the
9 E-connection material distributed by Cardinal Health?

10 A I'm not aware of specific false statements,
11 but I am aware broadly that Cardinal Health
12 collaborated to promote Kadian products.

13 Q You have one document cited in support of
14 that, correct?

15 A Well, no, I have more than one document.
16 There is the document we just reviewed, and then
17 there's this document, and --

18 Q Dr. Lembke, I hate to correct you about
19 your own report, but the first document we reviewed
20 in roman numerette No. 3 concerned Teva. The one --
21 the next one concerns Actavis; is that right?

22 A Yes, that's true, but it was both --
23 they're Cardinal Health, is my point.

24 Q Okay. So we've got the one we looked at

1 before, and now we've got this one we're looking at
2 in Exhibit 9. I'll represent to you that the Actavis
3 Bates number 0220239 is the same as the Bates number
4 that's given here, Allergan MDL 00016836, and if
5 that --

6 A Yes. Thank you for that.

7 Q If that's incorrect, I'll rely on one of my
8 colleagues to correct me, but I believe that's true.

9 So, again here we have an email between
10 Cardinal Health and a manufacturer, and you describe
11 that as having partnered, correct?

12 A Well, it's not just the email that's an
13 example of the partnering, it's the fact that they
14 were working together to think about ways --

15 Q Dr. Lembke, in your report the only thing
16 you cite in support of this partnership is this
17 email, correct?

18 A Yes.

19 Q Okay. And what we have here is an email,
20 but we don't actually have an e-connection
21 distribution showing Kadian being marketed in any
22 way, do we?

23 A No, but what we have, which I think is also
24 important, is a conversation between opioid

1 manufacturers and distributors about promoting the
2 product.

3 Q Dr. Lembke, you don't point in your report
4 to any actual promotion that resulted from this
5 communication here in Exhibit 9, do you?

6 A No, I didn't pursue it to see the outcome
7 of this conversation.

8 Q So you don't know whether any such
9 promotional email was ever actually sent?

10 A No. I assume that it was, but even
11 separate from that, even if it wasn't sent, this
12 represents to me evidence of an active dialogue
13 around promoting.

14 Q Dr. Lembke, do you know whether as a result
15 of this conversation or this dialogue there was ever
16 any marketing material sent by Actavis through the
17 Cardinal Health e-connection program?

18 A No.

19 Q And you don't know whether anyone, any
20 pharmacist or doctor in Cabell or Huntington, ever
21 received any materials about Kadian from Cardinal
22 Health, do you?

23 A No, but these were national campaigns, and
24 I assume that West Virginia was not an exception.

1 Q But, Doctor, we just established you don't
2 know whether this national campaign ever resulted in
3 anything being sent, do you?

4 A I don't, no.

5 Q You don't know?

6 A (Deponent shakes head.) No.

7 Q Just to be clear, when you say "no," what
8 you mean is "correct," you don't know whether
9 anything was actually sent; is that correct?

10 A That is correct.

11 Q There's a third instance that you cite in
12 your report, and again, you claim it's a partnership
13 on page 61. Do you see that on page 61, romanette
14 vii?

15 A Yes. Yes, I do. I see that.

16 Q Okay. And here, again, you have a citation
17 to a document, and I'm going to ask you to turn to
18 Exhibit 10.

19 A Okay.

20 Q So again, Exhibit 10, which is the only
21 document that supports your description of an
22 exchange between Cardinal and Covidien, is another
23 email exchange between Cardinal employees and
24 manufacturer employees, correct?

1 A Yes.

2 Q Okay. And in this email exchange, Cardinal
3 Health actually informs Covidien that it could not
4 display a banner ad on Cardinal's ordering platform
5 for pharmacists except in the case where pharmacists
6 had already searched for the product name, in this
7 case Exalgo. Do you see that?

8 A Yes.

9 Q So. Pursuant to this email, the only time
10 a pharmacist would see anything that could be
11 construed as marketing for Covidien's medication
12 Exalgo is that the pharmacist had already taken a
13 step to type into Cardinal Health's search bar
14 "Exalgo." Is that right?

15 A Well, yes, but I would draw attention to
16 the statement in this document that says, quote:
17 "While we can feature Exalgo on the ordering
18 platform."

19 So there was manipulation in the sense that
20 Exalgo was featured on an ordering platform.

21 Q Dr. Lembke, that is a striking statement
22 you just made, since you dropped the second half of
23 the sentence. Isn't it true that the sentence that
24 you just read is: "While we can feature Exalgo on

1 the ordering platform, it was deemed that it could
2 only be prompted by a search key word of 'Exalgo.'"

3 MR. ARBITBLIT: Objection.
4 Argumentative.

5 A I don't think that was a striking
6 statement. You had already said the second half
7 without saying the first half, so I am completing
8 your incomplete statement of that.

9 Q So let's see if we can reach agreement.
10 Dr. Lembke, is it true that under this email,
11 Cardinal Health's position was that the only way a
12 pharmacist placing an order could see the banner ad
13 from Covidien was if that pharmacist had already done
14 a key word search for the medication, quote,
15 "Exalgo," end quote?

16 A Yes. That is true, but even without the
17 pharmacist putting in Exalgo as a key word, Exalgo
18 was featured on the ordering platform. Also, I think
19 this email is striking for its tacit agreement that
20 this kind of collaboration between manufacturers and
21 defendants is, in fact, evidence of pushing a
22 controlled substance, which is why the (audio
23 indiscernible) removed it.

24 Q Move to strike everything the witness has

1 answered after the agreement.

2 Dr. Lembke, is it improper to provide
3 information to pharmacists about a new product?

4 MR. ARBITBLIT: Objection.

5 A If the information is accurate, it's not
6 improper.

7 Q Okay. And is there anything in your report
8 which indicates that information provided about
9 Exalgo by Cardinal Health was inaccurate?

10 A No.

11 Q Are you aware of any evidence that the
12 banner ad being discussed in Exhibit 10 ever actually
13 ran on Cardinal Health's ordering platform?

14 A I'm sorry. Is Exhibit 10 this last one,
15 "Good evening, Connie"?

16 Q Yes.

17 A Okay. No, I'm not aware of whether it ever
18 ran.

19 Q So it's true that in each of the three
20 instances we just looked at in your report where
21 you've claimed Cardinal Health worked with a
22 manufacturer, you don't have any proof in your report
23 that those marketing or advertisements ever were
24 actually enacted or that any pharmacist in

1 West Virginia ever saw them, do you?

2 A Again, I will say that the statement "We
3 can feature Exalgo on the ordering platform," to me
4 the word "feature" means they're going to make Exalgo
5 pop out on the ordering platform, where other opioid
6 products may not pop out, or where non-opioid
7 products may not pop out.

8 Q Dr. Lembke, do you know if that ever
9 actually happened?

10 A I have no reason to believe that it didn't
11 happen.

12 Q Not my question. Dr. Lembke, do you have
13 any proof that this banner ad ever actually happened
14 on Cardinal Health's platform?

15 MR. ARBITBLIT: Objection.

16 A Yes.

17 Q And Dr. Lembke, you're using the term
18 "popped out." Do you know what a banner ad is?

19 A I think so.

20 Q What do you believe a banner ad is?

21 A I believe it shows up in whatever is
22 featured on the screen.

23 Q So, Dr. Lembke, if a person searches for
24 something, let's say, in Google, they might get an

1 advertisement for something else based on a key word
2 that they've run; is that right?

3 A Yes.

4 Q And if the information that they receive is
5 truthful, is there any violation of FDA regulations,
6 to your knowledge?

7 MR. ARBITBLIT: Objection.

8 A Even if the information is truthful, it's
9 still directing the consumer's attention to that
10 product and influencing their behavior. I don't know
11 what the FDA's regulations on that are, but I do have
12 an opinion about whether or not that matters or that
13 has an impact.

14 Q Well, let's talk about who -- You're using
15 the term "consumer." Cardinal Health's ordering
16 platform, which is being discussed in these emails,
17 are you aware, Dr. Lembke, that that is used by
18 pharmacists placing orders for their pharmacies?

19 A I am very aware, and in using the word
20 "consumer," I was speaking of the pharmacist.

21 Q Okay. And pharmacists can't prescribe
22 medications, can they?

23 A They have an impact on what is prescribed.

24 Q Dr. Lembke, can pharmacists prescribe

1 medications?

2 A No.

3 Q And Dr. Lembke, to your knowledge, are
4 patients in the general public able to access
5 Cardinal Health's ordering platform?

6 A No.

7 Q In any of the three instances that we just
8 reviewed that are cited in your report, can you
9 identify any false or misleading statement?

10 A No.

11 Q Okay. I want to move on, Doctor, to your
12 Materials Considered. And in your Materials
13 Considered, you cited three Cardinal Health documents
14 that I would like to discuss with you. One we
15 already discussed, that's Exhibit 7. I'd like to
16 also ask you to look at Exhibit 6.

17 So this was cited in your Materials
18 Considered and it's dated July 18th, 2016. Do you
19 see it?

20 A Yes.

21 Q Okay. And at the top it's described as a
22 Service Flash. Do you see that?

23 A Yes.

24 Q Okay. And it's: "A weekly product and

1 service update to assist in your distribution needs."

2 Do you see that statement?

3 A Yes.

4 Q And do you understand that this was sent
5 exclusively to pharmacy customers of Cardinal Health?

6 A Yes.

7 Q And the first thing it says is it
8 highlights existing products with NDC changes,
9 manufacturer mergers, et cetera. Do you see that?

10 A Yes.

11 Q Is there anything wrong with informing
12 customers of changes to NDC numbers?

13 A Not that I know of.

14 Q Anything wrong with informing customers
15 about manufacturer mergers?

16 A No.

17 Q Okay. And the first item in this Service
18 Flash is something called Theophylline ER 300 mg and
19 450 mg. Do you see that?

20 A Yes.

21 Q Is this an opioid?

22 A No.

23 Q So --

24 A The opioid is on the next page.

1 Q Let's concentrate on the first page first.
2 Do you have any criticism of Cardinal Health for
3 distributing this information from a manufacturer
4 about a launch of a new medication to treat chronic
5 obstructive pulmonary disease?

6 A I would say it was -- I was surprised when
7 I reviewed these materials, the extent to which
8 Cardinal is communicating with pharmacists about
9 their products and putting that communication in
10 front of pharmacists.

11 Q Okay. Do you see that in this announcement
12 there are quotation marks on the first page
13 discussing the announcement by Alembic
14 Pharmaceuticals?

15 A I only -- oh, yes. I see that. Yes.

16 Q So Cardinal Health is providing a statement
17 from a manufacturer about a new product to
18 pharmacists, correct?

19 A Yes.

20 Q And manufacturers make statements about
21 their products on all sorts of forums, correct?

22 A Yes. Correct.

23 Q Some do so on TV and direct consumer
24 advertising, correct?

1 A Yes.

2 Q Some run ads in medical journals; is that
3 right?

4 A Yes.

5 Q And, in fact, some manufacturers have run
6 ads in prestigious medical journals, like JAMA,
7 correct?

8 A Yes.

9 Q What does JAMA stand for?

10 A The Journal of the American Medical
11 Association.

12 Q Is the Journal of the Medical Association
13 responsible for the content of each ad that runs in
14 it, in your view as a doctor?

15 MR. ARBITBLIT: Objection.

16 A I think they're responsible to some degree
17 about the fact that they're running ads in the first
18 place. I don't think that they have the bandwidth to
19 vet every single ad, but I think the fact that
20 they're even running ads means that they're somewhat
21 involved in promoting the product.

22 Q So if JAMA ran an advertisement about an
23 opioid, are they also responsible for any harm that
24 might have come from that opioid if a doctor then

1 subsequently prescribed in reliance on that
2 advertisement?

3 A To a very, very small degree, yes.

4 Q And same thing for, let's say, NBC. If NBC
5 runs an advertisement for a medical product, is NBC
6 responsible for people who may buy that medical
7 product in reliance on that advertisement?

8 MR. ARBITBLIT: Objection.

9 A I think it's important to make a
10 distinction between medical products broadly and
11 opioids, which are highly addictive and highly
12 lethal.

13 Q So as to my question, if we're talking
14 about opioids, if NBC ran an ad for opioids, would it
15 be responsible for any sales that resulted from those
16 advertisements?

17 MR. ARBITBLIT: Objection.

18 A I do think that the regulations around
19 opioid advertisements and promotions should be
20 scrutinized and considered as part of, you know, the
21 abatement process for this opioid epidemic.

22 Q Not an answer to my question. In your
23 view, is NBC responsible for any sales that occur as
24 a result of it having run an ad for an opioid

1 product?

2 MR. ARBITBLIT: Objection.

3 A Well, what I can tell you is my opinion is
4 that advertising opioid products in any venue has
5 contributed to the problem. That's my opinion --

6 Q Sorry. I didn't mean to cut you off. And
7 you believe then a prestigious medical journal like
8 JAMA is also responsible for any sales that result
9 from its running of advertisements for opioids,
10 correct?

11 MR. ARBITBLIT: Objection.

12 A Yes, I already answered that. I think they
13 bear some small part of the broader responsibility.

14 Q Okay. Well, let's look -- turn the page of
15 Exhibit 6 to the next page. So the second
16 announcement in this Service Flash sent to
17 pharmacists states: "Now available from Depomed."

18 Correct? Do you see in bold at the top, it
19 says, "Now available from Depomed"?

20 A Yes. Thank you. I do see that.

21 Q And then it says, "Dear Pharmacy Buyer,"
22 correct?

23 A Yes.

24 Q So this is directed to pharmacists, not

1 doctors, correct?

2 A That's correct.

3 Q And the full text reads:

4 A "Depomed announces the availability of
5 Lazanda 300 mcg fentanyl nasal spray, CII, in
6 addition to Lazanda 100 mcg fentanyl nasal spray,
7 CII, and Lazanda 400 mcg fentanyl nasal spray CII,
8 which are currently available."

9 Did I read that correctly?

10 A Yes.

11 Q And then it lists the three products,
12 correct?

13 A Yes.

14 Q Okay. To your knowledge, is anything in
15 this Service Flash that incorporates information from
16 Depomed untrue?

17 A No. But did you say milligrams or
18 micrograms? Sorry.

19 Q I said "MCG," because I wasn't sure what
20 MCG stands for. So MCG stands for micrograms; is
21 that right?

22 A Yes.

23 Q Is anything in this Service Flash sent by
24 Cardinal Health misleading?

1 A Not as far as I know.

2 Q Okay. Let's take a look at Exhibit 8 in
3 your box. And Exhibit 8 is the last of the five
4 Cardinal Health related documents you rely on for
5 your marketing opinion, correct, Doctor?

6 A Yes.

7 Q Okay. Let's look at Exhibit 8. And it
8 starts with an email, correct?

9 A Yes, it does.

10 Q Okay. And the second page is another
11 Service Flash, correct?

12 A Yes.

13 Q And this service flash is dated
14 November 22nd, 2013?

15 A Yes.

16 Q And, again, to your understanding, it's
17 sent to pharmacists; is that right?

18 A Yes.

19 Q And it states: "Introducing Abstral from
20 Galena Biopharma." Correct?

21 A Yes.

22 Q And it announces that:

23 "Galena Biopharma, Inc., is pleased to
24 announce the availability of Abstral fentanyl

1 sublingual tablets. Abstral is an opioid agonist
2 indicated for the management of breakthrough pain in
3 cancer patients 18 years of age or older who are
4 already receiving and who are tolerant to opioid
5 therapy for their underlying persistent cancer pain."

6 Did I read that correctly?

7 A Yes.

8 Q To your knowledge, is there anything untrue
9 about that statement?

10 A The use of the language "breakthrough pain"
11 perpetuates a false concept.

12 Q Does the FDA allow use of the term
13 "breakthrough pain"?

14 A I believe the FDA has used that term as
15 well.

16 Q Other than your disagreement with the use
17 of the term breakthrough pain, is there anything in
18 that paragraph that is false?

19 A Not false per se, but I think the statement
20 proceeds this that "Galena Biopharma is pleased to
21 announce the availability of Abstral fentanyl
22 sublingual tablets," exclamation point, is a subtle
23 form of promotion.

24 Q Are you aware of any doctor in Cabell

1 County or the City of Huntington who received this
2 document?

3 A No. But these are national campaigns
4 typically.

5 Q Well, in fact, it only went to pharmacists,
6 not any doctors, correct? Is that your
7 understanding?

8 A That's my understanding.

9 Q Okay. And this Service Flash doesn't
10 just -- well, let's go back to the top. Other than
11 your disagreement with the use of the term
12 breakthrough pain that the FDA also uses, and your
13 disagreement with the use of an exclamation point, is
14 there anything in that paragraph that you believe is
15 untrue?

16 A No.

17 Q Okay. And it's true that not only do we
18 have that introductory paragraph in Exhibit 8, but we
19 then have some ordering information that provides NDC
20 numbers for pharmacists; is that right?

21 A Yes.

22 Q And then there's also a statement below
23 that states, and I quote: "Abstral carries a Black
24 Box warning with important information regarding the

1 adverse effects of this Class II, CII, opioid agonist
2 and can cause serious breathing problems which can
3 lead to death, namely in patients not experienced
4 with opioid therapy. For complete prescribing
5 information and details on the Patient Assistance
6 Program, please visit www.abstral.com."

7 Do you see that statement?

8 A Yes, I do. And right below it are the
9 words paid advertisement.

10 Q Yes, they are. That's correct. Is there
11 anything untrue about the statement made about
12 Abstral and its Black Box warning?

13 A I don't see anything untrue in the
14 statement that you just read about the Black Box
15 warning.

16 Q And there is no further information
17 provided by Cardinal Health about Abstral to its
18 pharmacist customers that you're aware of, is there?

19 A No, but there is a website here. "Please
20 visit www.abstral.com.

21 Q True. Did Cardinal Health send the
22 contents of that website to its pharmacy customers?

23 A No, but they did highlight the link in
24 bold.

1 Q Well, actually it says paid advertisement.
2 So anyone reading this understands that it's not
3 actually Cardinal Health speaking, it's Galena
4 Biopharma; is that right?

5 A I don't think people reading -- first of
6 all, paid advertising is like in a two-point font, so
7 it's really hard to see on this piece of paper, which
8 is relevant. And I actually don't think that most
9 people know who pays for these things. It's quite a
10 mystery. It's all behind the scenes.

11 Q You don't think that when people see an
12 advertisement, they understand that the manufacturer
13 of that product is the one advertising it?"

14 MR. ARBITBLIT: Objection.

15 A I think if you ask the average person who
16 was advertising, they wouldn't necessarily be able to
17 tell you, nor would it be obvious looking at this
18 that it is a paid advertisement.

19 Q Even though it says on it "paid
20 advertisement"?

21 A Yeah, but the font is like five times
22 smaller.

23 Q So your objection is to the font size here?

24 MR. ARBITBLIT: Objection.

1 A Yes, and that's a legitimate objection.
2 Because what -- everybody knows, especially in this
3 distracted age, that images matter, font size
4 matters, flashing lights matter.

5 Q Who is responsible for the content on the
6 Abstral.com website, in your view?

7 MR. ARBITBLIT: Objection.

8 A Well, Galena Biopharma, Inc. But, again
9 there's such a shell game with the various opioid
10 companies that it's hard to know who's -- who really
11 owns what. I found it difficult to track that.

12 Q Do any of the Distributor Defendants to
13 your knowledge have any financial interests or
14 ownership interests of Galena Biopharma?

15 A I don't know.

16 Q Dr. Lembke, you talk a little bit about
17 font size and the way people perceive things. Do you
18 have any qualifications, any degrees that give you an
19 expertise in marketing and the impact of imagery on
20 pharmacists?

21 MR. ARBITBLIT: Objection.

22 A Well, I am a psychiatrist. So, I guess, I
23 qualify in the sense that I studied the brain.

24 Q And Dr. Lembke, beyond your psychiatry

1 degree, do you have any advance degrees or
2 certifications in marketing?

3 A No, but some of this really is common sense
4 too.

5 Q Dr. Lembke, other than the five documents
6 we just discussed, you didn't cite to any other
7 documents distributed by Cardinal Health in support
8 of your marketing opinion, did you?

9 A I don't believe so.

10 Q And you in your report don't point to any
11 evidence that Cardinal Health participated in any
12 programs related to free samples or coupons?

13 A That is correct.

14 Q And we talked earlier about advertisements
15 in JAMA. Do you recall that?

16 A Yes.

17 Q Well, are you aware that Purdue Pharma
18 advertised in the journal of -- the Journal of the
19 American Medical Association, JAMA?

20 A Yes.

21 Q And are you aware that the FDA sent a
22 warning letter to Purdue about its promotional
23 materials that appeared in JAMA?

24 A I'm not recalling a specific document to

1 that effect, but it could be that I reviewed that. I
2 reviewed many documents along those lines.

3 MR. PYSER: Brad, can you show
4 Exhibit 35, please.

5 That one is not in the box. My
6 apologies, Don.

7 MR. ARBITBLIT: That's okay.

8 MR. PYSER: You can register your
9 objection as a standing objection if you'd like.

10 MR. ARBITBLIT: Yeah, same standing
11 objection to the documents that weren't provided and
12 testimony based on it.

13 MR. FARRELL: Steve, can I have a
14 standing objection too?

15 MR. PYSER: They're being given away
16 cheap here, Paul.

17 BY MR. PYSER:

18 Q All right. Dr. Lembke, I'm showing what's
19 been marked as Exhibit 35. This is a warning letter
20 from the Department of Health and Human Services to
21 the executive vice president and chief operating
22 officer of Purdue Pharma. Do you see Exhibit 35?

23 A Yes, I do see it.

24 Q Okay. And if we go down to the first

1 paragraph, the warning letter concerns dissemination
2 of promotional materials for the marketing of
3 OxyContin tablets by Purdue, and then it says:

4 "Specifically, we refer to two Journal
5 advertisements for OxyContin that recently appeared
6 in the Journal of American Medical Association JAMA.
7 One October 2nd, 2002, and one November 13th,
8 2002." Do you see that?

9 A Yes.

10 Q Okay. And the FDA found, and I'm quoting
11 now from the second paragraph, that these, quote:
12 "Journal advertisements omit and minimize the serious
13 safety risks associated with OxyContin."

14 Do you see that?

15 A I do. Yep.

16 Q Okay. And do you regularly read JAMA, the
17 Journal of the American Medical Association?

18 A Yes.

19 Q Okay. Do you recall seeing a Purdue
20 OxyContin ad in JAMA?

21 MR. ARBITBLIT: Objection.

22 A No, I don't specifically recall, but I
23 probably was a recipient of such an ad.

24 Q In your opinion, did JAMA wrongfully

1 partner with Purdue to promote the sale of opioid
2 pain pills?

3 MR. ARBITBLIT: Objection.

4 A Yeah, as stated before, I think the
5 promotion of opioids to the extent that it has been
6 pursued in the last 30 years has contributed to the
7 problem, but the degree to which the JAMA is
8 responsible pales in comparison to the degree to
9 which the defendants in this case are responsible.

10 MR. PYSER: Brad, you can take the
11 document down. We're seeing your email right now,
12 Brad. There you go.

13 BY MR. PYSER:

14 Q Are you aware of any FDA warning letter
15 concerning any material that was passed from a drug
16 manufacturer through Cardinal Health?

17 A Not specifically.

18 Q How about AmerisourceBergen? Are you aware
19 of any FDA warning letter concerning any material
20 that was passed on to pharmacists or others by
21 Amerisource?

22 A Not that I can recall, no.

23 Q And finally, McKesson. Are you aware of
24 any FDA warning letter concerning any material that

1 was passed on to pharmacists or others -- excuse me,
2 I think I misspoke. Strike that. Finally, McKesson.
3 Are you aware of any FDA warning letter concerning
4 any material that was passed on to pharmacists or
5 others by McKesson?

6 A Not that I recall.

7 Q You published your book, Drug Dealer, MD,
8 in 2016, correct?

9 A Yes.

10 Q At the time you published, had you been
11 hired by plaintiff's lawyers as an expert witness for
12 opioid litigation?

13 A No. I had no awareness of the opioid
14 litigation and no contact with lawyers.

15 Q So on page 6 of your book -- and if you
16 want to see a copy of it, we have it at Exhibit 30.
17 On page 6 you wrote, quote:

18 "To every patient who has been addicted to
19 prescription drugs, to their loved ones, and to all
20 the doctors who went into medicine to do good but
21 feel trapped by a system gone awry."

22 Is that your language?

23 A Yes.

24 Q Prior to the time you published that book,

1 how long had you been researching and writing about
2 the opioid epidemic?

3 A I would say informally for, you know, about
4 16 years, and formally for about 6 years.

5 Q And did you try to be complete and thorough
6 in your book?

7 A I tried, yes.

8 Q Fair to say you spent thousands of hours
9 researching and writing?

10 A I don't know how many hours I spent. It
11 was a lot of time.

12 Q Let me ask you, Doctor, a little bit of
13 background. What drove your interest in this area of
14 addiction medicine?

15 A The harm that I was seeing -- the harm that
16 I saw being done to patients due to overprescribing.

17 Q And Doctor, I want to explore an area --
18 And Counsel, you're free to mark it
19 confidential if you want.

20 Do you have any personal experience within
21 your family of opioid addiction or opioid use?

22 MR. ARBITBLIT: Objection.

23 A Not really.

24 Q How did you decide who to interview for

1 your book?

2 A I used a method called qualitative
3 research, where interviews are conducted until themes
4 are saturated. And then based on those interviews,
5 more questions are raised, which then indicates
6 interviewing other individuals in order to answer
7 questions that come along. So it's an inductive
8 rather than a deductive process.

9 Q And did you, in choosing the people you
10 interviewed, did you try to choose to interview
11 people who you believe possessed an understanding of
12 the factors that led to the opioid epidemic?

13 A No, not necessarily. I wanted a broad
14 swath of representation. I wanted to interview
15 health care providers, wondering how they viewed
16 opioids, what their influence was, what their
17 experience was. I interviewed a diverse set of
18 patients, patients who had become addicted, patients
19 who hadn't become addicted, patients who said that
20 opioids were the only thing that helped their pain,
21 other patients who said opioids were unhelpful. So I
22 tried to get a very broad range of -- a broad sample.

23 Q And was your goal for you in your writing
24 to gain an understanding of the factors that led to

1 the opioid epidemic?

2 A Yes.

3 Q And one of the chapters in your book is
4 called, "Big Pharma Joins Big Medicine Collecting
5 Medical Science to Promote Pill Taking." Is that
6 right?

7 A Yes.

8 Q And that chapter is about opioid
9 manufacturers, correct?

10 A Primarily, not just opioid manufacturers,
11 also some various regulatory bodies that I was aware
12 of and had had an influence and an impact. Because
13 primarily they were influenced by opioid
14 manufacturers.

15 Q And you also concentrated a lot in that
16 chapter on Purdue Pharma, correct?

17 A Yes.

18 Q There is nothing in your book that mentions
19 Cardinal Health, is there?

20 A No.

21 Q And there is nothing in your book that
22 mentions McKesson, is there?

23 A No. I really only became aware of the role
24 of the distributors around 2015 or so.

1 Q Not my question, Doctor. My question is:
2 Is McKesson Corporation mentioned in your book?

3 A No.

4 Q And finally, is AmerisourceBergen
5 Corporation mentioned in your book?

6 A No.

7 Q And, in fact, there is nothing in your book
8 about the role of pharmaceutical distributors, is
9 there?

10 MR. ARBITBLIT: Objection.

11 A Not focused on distributors, no. I think
12 more broadly what I do talk about in my book, which
13 is the major theme of my book, is how increased
14 supply led to the epidemic. And certainly the
15 distributors have had a role in increasing the
16 supply, but I don't specifically mention
17 distributors.

18 Q Okay. Let's just be clear. You don't
19 mention pharmaceutical distributors anywhere in your
20 book, do you?

21 MR. ARBITBLIT: Objection.

22 A No.

23 Q And prior to the time you were retained as
24 an expert in the opioid litigation, had you ever

1 published anything in which you mentioned the role of
2 Cardinal Health, McKesson, or AmerisourceBergen in
3 creating or contributing to the opioid epidemic?

4 A No.

5 Q In 20 years of clinical experience prior to
6 this litigation, had you ever interacted with a
7 pharmaceutical distributor?

8 A No.

9 Q Okay. Dr. Lembke, are you familiar with
10 the term "suspicious orders" in the context of
11 distributors' shipments to pharmacies?

12 A Yes.

13 Q Have you reviewed any DEA documents
14 regarding what the DEA considers to be a suspicious
15 order?

16 A I believe I reviewed some DEA documents,
17 broadly detailing that, and I reviewed the Controlled
18 Substances Act, which I think might be a DEA
19 document. I'm not exactly sure if it came from the
20 DEA.

21 Q Have you reviewed any deposition
22 transcripts taken of DEA witnesses in this
23 litigation?

24 A Not that I recall.

1 Q Have you undertaken a review of any of the
2 distributors in this litigation, their suspicious
3 order monitoring systems?

4 A Not specifically.

5 Q Have you reviewed any specific orders that
6 the distributors in this case shipped to pharmacies
7 in Cabell County or Huntington?

8 A No.

9 Q Did you review the report of a man named
10 James Rafalski in forming your opinions?

11 A No.

12 Q I want to return to something you said at
13 your New York deposition. You testified there that
14 you had never designed a suspicious order monitoring
15 system. Do you recall that in your deposition?

16 A Yes, I do.

17 Q But then last week at the New York Frye
18 hearing, I asked you the same question, have you ever
19 designed a suspicious order monitoring system, and
20 you said yes. Do you recall that?

21 A Yes.

22 Q Okay. So were you being truthful last week
23 when you testified that you have, in fact, designed a
24 suspicious order monitoring system?

1 A Yes, I was being truthful. In that moment,
2 the way that that question occurred to me was whether
3 or not I had overseen designing a suspicious order
4 monitoring system from the perspective of a
5 clinician, which I have done. I have implemented a
6 system here in our department. So that was how I was
7 answering that.

8 Q So a suspicious order monitoring system at
9 Stanford -- Is it Stanford Hospital, I'm sorry,
10 Doctor?

11 A Yes, Stanford Hospital. Stanford Health
12 Care. Yes. I also, just in the academic detailing,
13 I've done a lot of teaching on what health care
14 providers can do to help steward and monitor opioid
15 pain pills.

16 Q Okay.

17 A So in a broad sense -- in a very broad
18 sense, for clinicians I've been involved in that.
19 I've not been involved in advising distributors on
20 their suspicious monitoring systems.

21 Q So when we're talking about the suspicious
22 order monitoring system at Stanford, that's talking
23 about physician prescribing that you're monitoring;
24 is that right?

1 A That's right.

2 Q And what does your system at Stanford do?
3 Can you describe that to me?

4 A Well, we check the prescription drug
5 monitoring database. We give a limited supply at
6 once of opioids. We try to get as much collateral
7 information beyond just what the patient tells us,
8 because we recognize that the patient may not be the
9 most reliable source in every instance.

10 So we talk to others -- there are other
11 providers. We check the medical record. We talk to
12 pharmacists. We talk to their members. We're also
13 looking more broadly hospital wise at how we can
14 intervene at the prescriber level to alert people to
15 the real science about opioids and safe prescribing.

16 Q Anything else? Any other major features of
17 the system you've designed?

18 A That's what I can think of now. There may
19 be some other things, but that's what I can think of
20 now.

21 Q Okay. So I've got four factors. The first
22 one that's part of your system at Stanford is
23 checking the PDMP, the prescription drug monitoring
24 program, correct?

1 A Yes.

2 Q And that's a system -- there is one in
3 California, correct?

4 A Yes.

5 Q Do you know if there is one in
6 West Virginia as well?

7 A Yes, there is.

8 Q Okay. And it's run by the State, right?

9 A Typically.

10 Q And doctors have access to it, correct?
11 Prescribing physicians?

12 A In some states they do, and in some states
13 they don't. It depends on the state.

14 Q How about West Virginia, do you know?

15 A I believe they have mandatory -- it's
16 mandatory for them to check it, I believe.

17 Q Do you know when that changed? When that
18 happened?

19 A I don't recall the exact date.

20 Q Do you know approximately? Is it within
21 the last five years, the last ten years?

22 A In the last five to ten years.

23 Q So PDMP, doctors have to check it. And in
24 the PDMP, what can doctors see?

1 A They can see all the prescriptions for a
2 controlled substance that that patient has received
3 within a given amount of time, within a given
4 geographic region, typically the state.

5 Q And do pharmacists have access to it as
6 well in West Virginia?

7 A I believe so, yes.

8 Q And do state enforcement bodies, law
9 enforcement, have access to the prescription drug
10 monitoring program in West Virginia?

11 A It varies state to state what access they
12 have and what kind of access, but I believe so, yes.
13 In West Virginia.

14 Q And to your knowledge, in West Virginia do
15 distributors have access to the PDMP system?

16 A I don't know.

17 Q How about in California, do you know if
18 distributors have access to the PDMP there?

19 A I don't know.

20 Q Can we agree the PDMP is an incredibly
21 valuable tool for doctors and pharmacists to make
22 appropriate decisions about prescribing and
23 dispensing medication?

24 A It is a valuable tool, yes. We can agree

1 on that.

2 Q And the other thing -- So that was factor
3 number one. Factor number two in your monitoring
4 system at Stanford is limiting supply; is that right?

5 A Yes. I would say -- I would phrase it
6 differently. I would say helping to steward the
7 supply.

8 Q Meaning smaller prescription amounts, so
9 instead of a 30-day supply, asking doctors to
10 prescribe seven days; is that right?

11 A Yes.

12 Q And the point of doing so is to limit the
13 number of opioids that doctors prescribe and
14 therefore the number of opioids that are available,
15 correct?

16 MR. ARBITBLIT: Objection.

17 A Yes.

18 Q And then the third element that you
19 described is collateral information, and by that you
20 meant learning more about your patients than what
21 they'll tell you themselves; is that right?

22 A Yes.

23 Q And that's helpful in limiting the misuse
24 of opioids, because patients may not always be honest

1 with their doctors; is that right?

2 A That's correct.

3 Q And so you're asking doctors to do extra
4 work to find out whether patients are telling the
5 truth based on their medical records and any other
6 information they can locate; is that right?

7 A Yes. I'm asking doctors to do what is
8 within the limits of their capabilities to steward
9 opioids. Every person in the supply chain has a
10 different capability to do that, and I'm encouraging
11 doctors in their specific role to do what they can
12 do.

13 Q And the capability of each portion of the
14 supply chain is constrained by what information is
15 available to that individual or entity; is that
16 right?

17 MR. ARBITBLIT: Objection.

18 A Yes, it's constrained by -- yes.

19 Q And the last element you mentioned is how
20 we can intervene to alert doctors to the real dangers
21 of opioids. That's a continuing medical education?
22 Is that part of that?

23 A Yes.

24 Q What are some of the other elements of how

1 you in your monitoring program at Stanford alert
2 doctors to information about opioids?

3 A We educate doctors about the way in which
4 the opioid pharmaceutical industry has created the
5 paradigm shift that led to increased prescribing,
6 contrary to the evidence. And we really tried to
7 bring home that even when a doctor thinks they're not
8 being influenced by various promotional material,
9 that there is an influence and that physicians need
10 to be very aware of that influence.

11 Q And it's your view that the paradigm shift
12 in opioid prescribing led to increased prescribing by
13 doctors of opioids; is that right?

14 A It's my view, that the increased supply led
15 to the epidemic, and that that was driven by opioid
16 prescribing, which was in turn driven by the
17 misrepresentations of the science and the massive
18 distribution.

19 Q Okay. And the information on which doctors
20 base their decisions, it's your belief that there was
21 a paradigm shift in the information that was being
22 provided to doctors about opioid prescribing,
23 correct?

24 A I believe that doctors were duped about the

1 safety and benefits of opioids.

2 Q And that was -- I'm not trying to fight
3 with you here, Doctor. That was something you have
4 described repeatedly as a paradigm shift, correct?

5 A Yes.

6 Q Okay. In your report you make reference
7 several times -- actually, let's return to this
8 Stanford program again. Would you describe the
9 Stanford monitoring program for opioids? Does it
10 have a title?

11 A I think it would be an overstatement to say
12 that this is a Stanford-wide program. This is a
13 program that I implemented, you know, in my addiction
14 medicine chemical dependence purview, and that I am
15 working with others in other departments to try to
16 work on similar types of interventions.

17 Q So even here today in 2020, your program
18 has not been fully adopted at your school, Stanford
19 Medical?

20 A Well, you know -- yeah. So fully adopted,
21 I mean, medicine changes very slowly, and it happens
22 in an IN-ER-TIVE (inaudible) fashion, and it's a very
23 slow-turning ship. So I would say I have had a huge
24 impact on the thinking in this area, not just at

1 Stanford, but nationwide, and that some of the
2 protocols and recommendations that I created have
3 been adopted nationwide and at Stanford.

4 But, you know, it's a slow-turning ship. I
5 mean, the subtitle of my book is "How Doctors Were
6 duped, Patients Were Hooked, and Why It's so Hard to
7 Stop." It's hard to stop because there's a whole
8 infrastructure that's in place that intensifies
9 opioid prescribing, that includes the influence of
10 the defendants. And you cannot do that overnight.

11 Q Doctor, when you use "the defendants"
12 there, do you intend to include manufacturers in that
13 as well?

14 A Yes.

15 Q You know that the manufacturers are not, in
16 fact, defendants in this case, right?

17 A Yes.

18 Q Doctor, do you know if any hospital or
19 doctors in Cabell County or Huntington have adopted
20 your -- the elements of your program that you just
21 described, those four elements?

22 A Can I check my report? That would help me
23 to do that.

24 So, yes. On page 46 of my report, I cite

1 the West Virginia Best Practices Tool Kit adopted in
2 2016. Quote: "One of our goals with these
3 guidelines is to dramatically reduce the use of
4 opioids in the first-line treatment options for
5 patients with pain and significantly increase the use
6 of non-opioid alternatives for these patients."

7 Q And do you know whether --

8 A Sorry. There is more. Could I just finish
9 it?

10 Q You are reading from page 46, correct?

11 A Yes.

12 Q Okay. Do you know whether the
13 West Virginia Attorney General's best practices for
14 prescribing opioids in West Virginia is followed by
15 doctors within Cabell and Huntington?

16 A No, but I assume that it is based on the
17 decrease in opioid prescribing in West Virginia over
18 the last couple of years.

19 Q Have you done any studies or interviews to
20 find out whether doctors in Cabell or Huntington are
21 following the best practices for prescribing opioids
22 in West Virginia?

23 A I have not done any interviews with
24 individual doctors, but again, the prescribing rates

1 speak for themselves.

2 Q Okay. I'm not asking about the prescribing
3 rate. Again, Doctor, you have got to just answer the
4 question, okay? What I asked is whether you're aware
5 of whether -- and whether you have done any studies
6 or any interviews to determine whether doctors in
7 Cabell and Huntington are following the best
8 practices for prescribing opioids in West Virginia.
9 Have you done any studies?

10 MR. ARBITBLIT: Objection.

11 A Well, my method, you know, which I outlined
12 in the Frye hearing -- and you were there -- is to
13 look at the best science available, and that includes
14 looking at prescribing rates in Cabell County, which
15 have gone down by about 50 percent since their peak.
16 So I interpret that as evidence that they are
17 following some of these best practices. It's time to
18 get opioid prescribing more in line with what it
19 should be.

20 Q And have you interviewed any doctors in
21 Cabell or Huntington to discuss with them their
22 practices for prescribing opioids?

23 A No.

24 Q In your report you make several

1 references -- or you reference several times
2 something you call the efficient supply chain. Do
3 you recall saying that in your report?

4 A Yes.

5 Q Is there anything inherently wrong with a
6 supply chain being efficient and providing medication
7 to pharmacies quickly when they order it?

8 MR. ARBITBLIT: Objection.

9 A If that supply change is supplying opioids,
10 yes, there's something wrong with that.

11 Q Okay. So if a pharmacy orders diabetes
12 medication and it gets there the next day, that's
13 okay, right?

14 MR. ARBITBLIT: Objection.

15 A Yep.

16 Q And if a pharmacy orders medication to
17 fight cholesterol and it gets there the next day,
18 that's a good thing, right?

19 A Okay. Yes.

20 Q But it's your belief that when a pharmacy
21 orders opioid medication -- well, let me strike that.
22 When a pharmacy orders opioid medication, do you
23 object to that medication arriving the next day?

24 MR. ARBITBLIT: Objection.

1 A The frame of your question, I think, is not
2 really capturing my opinion, and I think my opinion
3 is really well echoed on page 95 of my report, where
4 the Healthcare Distribution Management Association,
5 which is a distributor organization, said, quote:

6 "The fact is that 200 million pills over a
7 four-year period is a significant problem. The story
8 is made worse given the following: The distributors
9 do not want to make their sales data public."

10 So --

11 Q Dr. Lembke --

12 A It's the volume of the pills that's really
13 concerning, if you have an efficient distribution
14 supply chain that's oversupplying the population.

15 Q Dr. Lembke, do you agree with me there are
16 times when patients need opioids? We talked about
17 this before.

18 MR. ARBITBLIT: Objection. Asked and
19 answered.

20 A Yes, I agree.

21 Q And when a patient needs opioids, do you
22 agree that it should be available to that patient and
23 their doctor?

24 MR. ARBITBLIT: Objection.

1 A As long as the judgment that determines
2 opioids were necessary was not influenced by fake
3 news.

4 Q Dr. Lembke, yes or no. When opioids are in
5 fact necessary, do you agree it is of societal good
6 that they be made available for patients?

7 MR. ARBITBLIT: Objection.

8 A Yes, if they are, in fact, necessary and if
9 the benefits to the individual and to the public
10 outweigh the risk.

11 Q Are you aware that the DEA's Office of
12 Diversion Control has described their mission as
13 preventing diversion of controlled substances while
14 ensuring a, quote, "adequate and uninterrupted supply
15 for legitimate medical, commercial, and scientific
16 needs"? Do you agree that that is a worthy goal?

17 MR. ARBITBLIT: Objection.

18 A Yes.

19 Q Do you agree that it's important that
20 individuals are able to receive medication that is
21 necessary and appropriately prescribed?

22 MR. ARBITBLIT: Objection.

23 A Again, it depends on whether or not the
24 medical necessity is based on science.

1 Q And that's an individualized decision based
2 on each patient and each doctor, correct?

3 MR. ARBITBLIT: Objection.

4 A No.

5 Q Well, Dr. Lembke, in order to make a
6 decision as to whether a particular prescription is
7 appropriate, would you have to know something about
8 the patient involved?

9 MR. ARBITBLIT: Objection.

10 A Yes.

11 Q Okay. So the decision as to whether a
12 prescription is appropriate is, in fact, an
13 individualized decision, correct?

14 MR. ARBITBLIT: Objection.

15 A No.

16 Q Dr. Lembke, if you need to know something
17 about the patient, how is it not an individualized
18 decision?

19 A Because the information about the patient
20 has to go through the filter of the doctor's brain of
21 all of the things that they've learned about that
22 medication, and if they've learned things that aren't
23 true, they can't make an informed judgment.

24 Q I'm not disputing that, Doctor. The

1 question is simply: Isn't it an individualized
2 decision that a doctor makes for each patient as to
3 what medication is appropriate for that patient?

4 MR. ARBITBLIT: Objection. Asked and
5 answered.

6 A Yes, it's not individualized, because we
7 have guidelines and we have algorithms, and we know
8 that there are certain types of patients that should
9 receive medications and certain doses and others that
10 don't.

11 So it's not individualized to the extent
12 that any doctor can decide any medication for any
13 patient. You have to base it on, you know, real
14 evidence. And you have to acknowledge that there are
15 a lot of other factors that are not real evidence
16 that influence doctors' decisions.

17 Q So you mentioned guidelines and algorithms.
18 Should doctors consider guidelines and algorithms as
19 to opioid prescribing when they make a decision as to
20 whether or not to prescribe a medication?

21 MR. ARBITBLIT: Objection.

22 A Yes. They are typically influenced by
23 guidelines and algorithms.

24 Q Do you agree that it's critical to make

1 sure that legitimate medical need for all types of
2 medications is met?

3 MR. ARBITBLIT: Objection. Overbroad.

4 A Yes.

5 Q And if patients can't get medication, there
6 will be human suffering? Do you agree with that
7 concept?

8 MR. ARBITBLIT: Objection. Overbroad.

9 A Yeah, I agree that it's overbroad, because
10 there may be more suffering by prescribing the
11 medication, and that's what you need to weigh into
12 the mix. It's always a cost benefit or risk benefit.
13 And it's also not just short term, but also long
14 term.

15 Q And who is it who makes that weighing
16 decision, weighing human suffering if patients can't
17 receive medication versus the possible negative
18 impacts of medication? Who makes that decision
19 weighing those?

20 A So in today's health care system, that
21 decision is often made collectively by the people who
22 run the hospital, by The Joint Commission which
23 creates quality measures, by -- you know, systemic
24 issues that have to do with third-party payers.

1 So there are lots of different factors.
2 And I really described this in my book. This is not,
3 you know, a new opinion on my part.

4 MR. ARBITBLIT: Steve, can we take a
5 break? We've been going for about an hour and 20
6 minutes.

7 MR. PYSER: Sure. We'll take one
8 really soon.

9 BY MR. ARBITBLIT:

10 Q So weighing the risks and benefits of a
11 medication, in your view -- I just want to create a
12 list of the people who have responsibility for doing
13 that. Doctors are involved with that decision, fair?

14 MR. ARBITBLIT: Objection.

15 A Yes.

16 Q Are pharmacists involved in that decision?

17 A I think so. They have a role, yeah.

18 Q You mentioned third-party payers. Are they
19 involved in the decision?

20 A Yes.

21 Q People who run hospitals you mentioned.
22 Are they involved in the decision?

23 A Yes.

24 Q Anyone else?

1 A The Joint Commission, the Federation of
2 State Medical Boards, the FDA, the DEA, and also,
3 importantly, opioid manufacturers, distributors, and
4 pharmacies.

5 Q What is distributors' role in your view in
6 balancing the legitimate need for medication versus
7 the dangers of certain medications?

8 A Distributors have a role in monitoring and
9 alerting for suspicious orders. And the distributors
10 have a role in terms of their collaboration with
11 manufacturers to promote opioid products. And some
12 distributors have been involved in direct to
13 pharmacists, direct to patients, and promotional
14 material.

15 MR. PYSER: We can take a break now,
16 Doc.

17 THE VIDEOGRAPHER: The time is 3:27.
18 We're now going off the record.

19 (A recess was taken.)

20 VIDEOGRAPHER: The time is 3:33.
21 We're now back on the record.

22 BY MR. PYSER:

23 Q Welcome back, Dr. Lembke. I'd like you to
24 turn to page 131 of your report, Exhibit 1.

1 MR. ARBITBLIT: Page again, please,
2 Steve?

3 MR. PYSER: 131.

4 MR. ARBITBLIT: Thank you.

5 BY MR. PYSER:

6 Q Dr. Lembke, in paragraph A under Opinion 8,
7 you write: "There's a clear causal link between
8 prescription opioid exposure, prescription opioid
9 misuse, and opioid addiction."

10 Do you see that?

11 A Yes.

12 Q Okay. And that word "causal" was not in
13 your Ohio or New York reports; is that right?

14 A To be 100 percent sure, you know, I would
15 have to look at those other reports. I believe you,
16 but I don't specifically remember.

17 Q What is the causal link between opioid
18 exposure, misuse, and addiction, in your own words?

19 A Okay. So opioids change the brain. They
20 work on the (inaudible/indiscernible) reward pathway
21 such that there is a process called neuroadaptation,
22 where over time the individual needs more and more to
23 get the same effect. And they become physically
24 dependent on opioids. And they experience withdrawal

1 when the opioids are stopped. And they can also
2 develop the disease of addiction, which is the
3 continued compulsive use of a substance despite harm
4 to self and/or others.

5 One of the biggest risk factors for
6 developing addiction is simple access to that drug,
7 and exposure to that drug, and the brain changes
8 wrought by that drug. In addition to addiction,
9 opioids are highly lethal and they can kill. And so
10 even people who are not addicted and not misusing can
11 die from opioids.

12 Q And do you have a percentage on, of all
13 patients who take opioids, how many suffer lethal
14 consequences among those who are not addicted or
15 suffering from opioid use disorder? So people who
16 are prescribed opioids using them legitimately, do
17 you know a percentage of death rate on that?

18 MR. ARBITBLIT: Objection.

19 A I don't have a specific number for that,
20 but that occurs. It is well-known and documented in
21 the medical literature.

22 Q And when you say prescription opioid
23 exposure, exposure could mean -- just going to give
24 you one example, and I'll give you additional. One

1 example of exposure could be a patient prescribed by
2 a doctor who fills their own prescription and takes
3 as directed. That's one version of exposure,
4 correct?

5 A Yes.

6 Q And a different version of exposure, you
7 could -- an individual could become exposed to
8 opioids by taking prescription opioids that were not
9 prescribed for them, correct?

10 A Yes.

11 Q And when you say prescription opioid
12 exposure, do you mean both of those scenarios, people
13 taking opioids as prescribed and people taking
14 opioids outside of a prescription for them?

15 A Yes.

16 Q Are you aware that the DEA establishes
17 production quotas for controlled substances every
18 year?

19 A Yes.

20 Q Have you ever participated in the DEA's
21 quota process to determine the medical, scientific,
22 research and industrial needs of the United States?

23 A No.

24 Q Have you ever written a letter to the DEA

1 through the regulatory process and argued that the
2 quota for opioids in the United States is too high?

3 A I have testified at a REMS hearing, so I
4 believe there were DEA representatives there.

5 Q That wasn't my question. My question was:
6 Have you ever written a letter or otherwise
7 petitioned the DEA to tell them that you believe the
8 quota is set too high?

9 MR. ARBITBLIT: Objection.

10 A Well, I did testify at that REMS hearing
11 about the quota being too high, about there being an
12 oversupply.

13 Q When was that?

14 A I'd have to look at my CV.

15 Q Is it -- You don't need to get the exact
16 date. Is it more than five years ago or less than
17 five years ago?

18 A I would say approximately five years ago.

19 Q And in the four years or so -- four to five
20 years that have gone by since then, have you
21 petitioned the DEA in any way to argue that the quota
22 today for opioids is too high in the United States?

23 A No.

24 Q On pages 18 and 19 of your report, you

1 describe -- this starts at the bottom of page 18,
2 numerette iii. You give three separate ways
3 prescription drugs can be diverted. Do you see that?

4 A Yes, I do.

5 Q And the first is diversion before a
6 prescription is even filled. For example, by theft
7 from a production facility or theft from a retail
8 pharmacy?

9 A Yes.

10 Q And as to that first category, are you
11 offering any opinions about theft from distributors?

12 A I'm sorry. Could you -- I didn't quite
13 hear one of the words.

14 Q Sure. It's in that first category, theft.
15 Are you offering any opinion about any theft from a
16 distributor defendant in this case?

17 A No.

18 Q Is it your understanding that actual theft
19 from distributors is exceedingly rare?

20 A I don't know about -- I don't have an
21 opinion on how rare or not rare that is.

22 Q The second category of diversion you
23 discussed is the filling of a prescription, and you
24 say, "e.g., pursuant to doctor shopping and high

1 frequency prescribers." Do you see that?

2 A Yes.

3 Q In terms of frequency of diversion, do you
4 know what percentage of diversion that example makes
5 up?

6 A I don't have a specific percentage, no.

7 Q How about the third, diversion after a
8 prescription has been filled?

9 A What's your question about that? Sorry.

10 Q Do you know of all diversion, what
11 percentage of diversion is prescription after a
12 prescription has been filled, for example, by
13 transfer or sale to a third party?

14 A No, but my sense is that that is high.

15 Q That is the most common of the three that
16 you list there on pages 18 and 19 of your report?

17 MR. ARBITBLIT: Objection.

18 A I would say that's the aspect of diversion
19 that I'm most familiar with. In my experience,
20 common, but I don't really have a sense of
21 quantifying it.

22 Q As to this third type of diversion, do you
23 agree that after a prescription for an opioid has
24 been shipped to a pharmacy, the distributor is unable

1 to control what happens to it?

2 A I think the distributor has upstream
3 responsibility to prevent diversion after it's been
4 filled.

5 MR. ARBITBLIT: Steve, I'm going to
6 interpose another objection. This precise line of
7 questioning has been gone over at previous
8 depositions, and according to Judge Wilkes' ruling on
9 Tuesday, we should not be plowing old ground.

10 MR. PYSER: I've gone to great pains
11 not to plow old grounds. I don't think that's
12 correct. If you want to point me to a page and line
13 cite, I'm happy to look at it. But we'll continue on
14 briefly on this.

15 Q Dr. Lembke, do you agree with me that
16 distributors don't know the identities of patients
17 who receive prescription opioids from pharmacies?

18 A I don't really know what they know
19 regarding patients.

20 Q You just don't know one way or the other?

21 A No.

22 Q Do you know from your experience as a
23 doctor whether any prescription that you have written
24 has been diverted?

1 A I don't have confirmation of any specific
2 prescription that I've written being diverted.

3 Q Are you aware of any of your patients
4 misusing opioids that you prescribe for them?

5 A How are you defining "misuse" in this
6 context?

7 Q Used to get high for a nonmedical purpose.

8 MR. ARBITBLIT: Objection.

9 A I don't have a specific incidence in a
10 patient to whom I was prescribing.

11 Q Are you aware of misuse of opioids by
12 patients who are under your care?

13 A I am aware of historical misuse, not linked
14 to any named prescriber. So I'm very aware of
15 pattern in general among my patients.

16 Q Have you attempted to find the name of any
17 prescriber for your patients who have prescribed
18 opioids that have been misused, so you could warn
19 them about the misuse?

20 A My patients did not present the information
21 in a way that I would be capable of warning anybody.
22 They were -- They were understandably reluctant --
23 sorry, let me just finish -- they were understandably
24 reluctant to provide the specifics about the

1 prescribers in that situation.

2 Q Have you ever --

3 A Sorry, and just so I can fully answer the
4 question. And it was often historical, meaning part
5 of what led up to their becoming addicted and then
6 presenting to me.

7 Q Have you ever asked one of your patients
8 the name of the physician who prescribed opioids that
9 they misused?

10 MR. ARBITBLIT: Objection.

11 A I can't recall a specific incident when I
12 asked that, no.

13 Q Let's talk briefly about rates of
14 diversion. Do you understand what I mean by that?
15 How often opioid medication is diverted?

16 A Okay.

17 Q If you wanted to calculate or measure the
18 rate of diversion, would speculation be an acceptable
19 way to measure the rate of diversion?

20 A I don't know. Could you give me a specific
21 example?

22 Q Well, Doctor, you publish in medical
23 journals, correct?

24 A Yes.

1 Q And if you wanted to say something about
2 the rate of diversion, would it be acceptable in a
3 peer reviewed medical journal to offer as your basis
4 for rate of diversion nothing more than pure
5 speculation?

6 MR. ARBITBLIT: Objection.

7 A Well, I mean, pure speculation implies that
8 that individual had no idea at all what formed that
9 speculation. I do think that -- I mean, you know,
10 you asked about econometric modeling. Econometric
11 modeling is, to some extent, based on speculation,
12 based on a model that's created.

13 So I think that the question is, you know,
14 hard to answer. You know, what -- how are you
15 defining "speculation."

16 Q So Dr. Lembke, in putting together your
17 report, you tried to find concrete, supportable
18 information, correct?

19 A Yes.

20 Q You tried not to speculate, you tried to
21 find proof for the things that you said in your
22 report, true?

23 A Yes.

24 Q Okay. And one of the documents you quote

1 from in your report is an NASEM report. Do you know
2 what an NASEM is? Or what the NASEM is?

3 A Yes.

4 Q What is it?

5 A The National Academy for Science
6 Engineering and Medicine.

7 Q Okay. And let's look at page 18 and 19 of
8 your report, same paragraph we were just looking at.
9 It talks about the NASEM report, right?

10 A Yes.

11 Q Okay. And at -- towards the end of the
12 paragraph, it states:

13 "The DEA reports that in recent years
14 distributors in the United States disbursed 12 to 15
15 billion dosage units of opioid narcotics to retail
16 level purchasers, suggesting that total diversion is
17 on the order of 2.5 to 4 billion dosage units."

18 Do you see that?

19 A Yes.

20 Q Okay. So that would be a rate of diversion
21 roughly 20 to 25 percent, correct?

22 A Yes.

23 Q Other than the NASEM, do you have any other
24 basis for proffering an opinion on the rate of

1 diversion?

2 A No.

3 Q Do you know the basis for an NASEM's
4 estimation that between 2.5 and 4 billion dosage
5 units were diverted?

6 A I believe they used ARCOS data.

7 Q And do you know how they calculated the
8 rate of diversion?

9 A No.

10 Q Is it your understanding that their
11 methodology is generally accepted and reliable,
12 that's why you used it?

13 A Yes.

14 Q Let's take a look at Exhibit 14, if you
15 could. And this is an excerpt of the NASEM article
16 you cited. And it's a long excerpt, so we have the
17 full section. It was a multihundred page document,
18 so we (---) some trees here.

19 If you look at Exhibit 14, there's a
20 page 223, and the paragraph in the center of that
21 page begins "Surveys moreover"?

22 A Yeah.

23 Q Okay. So about halfway through that
24 paragraph it states:

1 "Thus, the 564 million self-reported days
2 in the NSDUH may correspond to more like 1 billion
3 actual days. If the average dose per day for NSDUH
4 respondents," and can you tell us what NSDUH
5 respondents means?

6 A The National Survey for Drug Use and
7 Health.

8 Q "Equals the DDDs." What's DDDs?

9 A I don't know. You would have to go to
10 wherever it's mentioned. Daily doses or ...

11 Q If you turn to the page before, at the
12 bottom it's: Defined daily doses?

13 A Right. Okay.

14 Q So the defined daily doses:

15 "Underpinning the 39,487 DDD's per million
16 figure, then dividing that 1 billion by the
17 4.6 billion DDDs posited, one might speculate that
18 very roughly 20 to 25 percent of prescription opioids
19 in the United States are used nonmedically."

20 Do you see that?

21 A Yes.

22 Q Is that where we got this 25 to 25 percent
23 figure?

24 A Yeah.

1 Q Okay. And in order to get there, this
2 article takes the actual reporting of 564 million and
3 doubles it -- or close to doubles it to 1 billion.
4 Do you see that?

5 A Yes.

6 Q Okay. So what this survey report is doing
7 is taking a statistic that would lead to a roughly 10
8 to 12 percent figure, and because it's assuming that
9 reporting is inadequate, it just doubles it; is that
10 right?

11 A That's right. And there is a good basis in
12 the medical literature for doing that in this
13 instance.

14 Q But there is no basis in the survey data to
15 actually find 20 to 25 percent of prescription
16 opioids in the United States are used nonmedically,
17 correct?

18 MR. ARBITBLIT: Objection.

19 A Again, I think that because it's well-known
20 that people underreport the highly stigmatized
21 behavior of misuse and addiction, that it's
22 reasonable -- and that's established in literature
23 and a number of different studies -- it's reasonable
24 to double the 546 million to 1 billion.

1 Q But even the NASEM in describing its figure
2 states that it might speculate that very roughly 20
3 to 25 percent of prescription opioids are used
4 nonmedically, correct?

5 MR. ARBITBLIT: Objection.

6 A That's what it says, yes.

7 Q Okay. But when you report that in your
8 report, you don't report that it's based on, quote,
9 "very rough speculation," you take that figure and
10 apply it as an absolute; is that right?

11 MR. ARBITBLIT: Objection.

12 A I don't think that that's a fair
13 representation of what I've done in my report. I
14 simply, at the same rate of diversion reported by say
15 NASEM for the period reviewed, I'm just saying for
16 their statement, this would represent diversion on
17 this order. And NASEM, furthermore, is a highly
18 respected group of scientists that I believe to be
19 reliable, and I'm not alone in that.

20 Q And is it true, Dr. Lembke, that your
21 statistics are based on this 20 to 25 percent figure
22 in the NASEM report, correct?

23 A Yes.

24 Q Is it your opinion, Dr. Lembke, that

1 opioids are not effective to treat chronic pain?

2 A In the vast majority of people with chronic
3 pain, opioids are not effective treatment. And carry
4 significant risks.

5 Q And your view is that opioids should not be
6 prescribed to treat chronic pain patients, even after
7 non-opioid alternatives fail to relieve pain,
8 correct?

9 A Yes. In the vast majority of cases.

10 Q And to support that in your report at pages
11 82 and 83, you cite a fairly new position by the
12 Department of Veteran Affairs and the Department of
13 Defense that opioids should not be prescribed for
14 chronic pain; is that right?

15 A Yes. But what page numbers were those?

16 Q Sure. Page 82 and 83.

17 A Right. Yes, that's right.

18 Q Okay. Other than this VA/DoD guideline
19 that you cite, can you name another federal or state
20 agency that recommends against long-term opioid
21 therapy for chronic pain after non-opioid
22 alternatives have failed?

23 A I'm not aware of any other guideline that
24 states it that explicitly, but there are other

1 guidelines in which that is implied, for example, the
2 CDC guidelines from 2016, as well as the
3 West Virginia Best Practices Tool Kit.

4 Q So it's your understanding that the
5 West Virginia Best Practices Tool Kit recommends
6 against use of opioids as a long-term therapy for
7 chronic pain after non-opioid alternatives have
8 failed?

9 A I'm not saying that the Best Practices Tool
10 Kit explicitly says that, but that is certainly the
11 spirit of the Tool Kit. It's on page 46 of my
12 report. Their goal is to "dramatically reduce the
13 use of opioids as a first-line treatment option for
14 pain -- for patients with pain," and, quote,
15 "significantly increase the use of non-opioid
16 alternatives for these patients," unquote.

17 Q Okay.

18 A "Take every possible step to utilize
19 non-opioid options first."

20 Q Correct. When we're talking about
21 first-line treatment, they're recommending as a first
22 step try something that's non-opioid, correct?

23 A Yes. They are recommending that, along
24 with dramatically reducing the use of opioids.

1 Q But the VA and DoD go a step further and
2 they recommend against long-term opioid therapy, even
3 after non-opioid alternatives have failed, correct?

4 A Yes.

5 Q And you mentioned the CDC before. The
6 VA/DoD guideline is stronger than the CDC guidelines
7 about use of opioid therapy for long-term chronic
8 pain, correct?

9 A I would agree with that, yes.

10 Q In fact, in your report, you say -- you
11 quote the CDC guidelines, and that states that:
12 "Nonpharmacologic therapy and non-opioid
13 pharmacologic therapy are preferred for chronic
14 opioid, and clinicians should consider opioid therapy
15 only if expected benefits for pain and function are
16 anticipated to outweigh risks to the patients."

17 Correct?

18 A Yes.

19 Q Would it be fair to say that your hope is
20 that one day your opinion that opioids should not be
21 used to treat chronic pain at all will become more
22 common in the medical community?

23 A Unless some other evidence comes to light,
24 yes.

1 Q But today, that's an outlier opinion. Most
2 doctors use opioids more frequently than you would
3 recommend, correct?

4 MR. ARBITBLIT: Objection.

5 A The fact that many doctors use opioids more
6 frequently than I and many others would recommend
7 does not mean that my opinion is outlier. Those are
8 two separate things.

9 Q Dr. Lembke, do most doctors prescribe
10 opioids more frequently than you would recommend?

11 MR. ARBITBLIT: Objection.

12 A It really depends on the patient population
13 that you're talking about.

14 Q For chronic pain patients, do you believe
15 doctors prescribe too many opioids today for chronic
16 pain patients?

17 MR. ARBITBLIT: Objection.

18 A There are instances with chronic pain where
19 opioids -- where patients have become physiologically
20 dependent on those opioids and need somebody to
21 prescribe for them and can't find anybody. So
22 they've been referred to as opioid refugees.

23 In those cases, I think that doctors are
24 underprescribing opioids, because we have a

1 professional responsibility to take care of the
2 patients that we've harmed by putting them on opioids
3 in the first place, and that includes helping them
4 to -- taking them off more slowly and in a humane
5 way. So the answer depends on the circumstance.

6 Q You said as part of your answer the
7 patients that we've harmed. You're speaking there of
8 the medical community that you believe has
9 overprescribed opioids, correct?

10 A Well, the medical community as to the
11 defendants.

12 Q Are you familiar with any distributor
13 defendant ever having prescribed an opioid?

14 MR. ARBITBLIT: Objection.

15 A No.

16 Q Now, the VA/DoD position that we were just
17 discussing, that came out in 2017, correct?

18 A I'll take your word for it. I can't see
19 the date here.

20 Q Do you agree with me that it's a recent
21 change in position?

22 MR. ARBITBLIT: Objection.

23 A Well, I mean, I don't think -- I mean, it
24 was three years ago. So 2017, 2018 -- yeah, a couple

1 of years ago.

2 Q And before that, the VA and the Department
3 of Defense had different guidelines for treatment of
4 pain, correct?

5 A Yes, because they were also duped.

6 Q So we'll add them to your list of people
7 who were duped. The Department of Veteran Affairs
8 and the entire Department of Defense was also duped
9 as to the effectiveness of opioids; is that your
10 testimony?

11 MR. ARBITBLIT: Objection.

12 A The VA health care system. I don't think
13 you have to include the whole Department of Defense.

14 Q The VA health care system was duped as to
15 the effectiveness of opioids, correct?

16 A Yes, which is why they're changing their
17 guidelines, drastically revising them.

18 Q And sitting here today, are you aware of
19 any communication from a distributor defendant to the
20 VA about the appropriate use of opioid medications?

21 A No.

22 Q It's true, Doctor, that the CDC still
23 advises opioids may be prescribed to treat chronic
24 pain, correct?

1 A Can you show me the specific language that
2 you're referring to?

3 Q Sure. If you look at Exhibit 15 in your
4 binder.

5 And I'm looking at the third page of
6 Exhibit 15. And Exhibit 15 is titled "CDC Guidelines
7 for Prescribing Opioids for Chronic Pain." Is that
8 right?

9 A I'm sorry. Where are you seeing that?

10 Q Yeah, if we look at the title of Exhibit
11 15, it's titled "CDC Guidelines for Prescribing
12 Opioids for Chronic Pain," correct?

13 A Yes, it is.

14 Q And given just the title, is it fair -- can
15 we agree that the CDC Guidelines do include
16 prescribing opioids for chronic pain?

17 A No. I wouldn't -- I wouldn't assume that,
18 based on the title.

19 Q Okay. Well, if we look at CDC
20 recommendations on page 3, Item No. 1 says: "Opioids
21 are not a first-line therapy." Correct?

22 A Yes.

23 Q So before using opioids for chronic pain,
24 this is saying doctors should try something else,

1 correct?

2 A Yes.

3 Q And this is a new policy recommendation
4 from the CDC within the last three years or so,
5 correct?

6 MR. ARBITBLIT: Objection.

7 A Do you have a date on the document?

8 Q Unfortunately, I don't -- actually -- yeah,
9 I don't on this one.

10 A Okay.

11 Q Are you familiar with when the CDC
12 recommendations on chronic pain and opioid use
13 changed?

14 A I'm not familiar with the specific date,
15 and I wouldn't say that their original
16 recommendations substantively changed.

17 Q Okay.

18 A I mean, they came out in 2016. I don't
19 think it was substantively changed.

20 Q As part of the current recommendations
21 we're looking at here in Exhibit 15, Item No. 2 under
22 CDC recommendations on page 3 states:

23 "Before starting opioid therapy for chronic
24 pain, clinicians should establish treatment goals

1 with all patients, including realistic goals for pain
2 and function, and should consider how opioid therapy
3 will be discontinued if benefits do not outweigh
4 risks."

5 Do you see that?

6 A Yes.

7 Q So for some patients, the CDC is saying
8 that if you've gone through these steps, opioid
9 therapy for chronic pain may still be the best
10 course, correct?

11 MR. ARBITBLIT: Objection.

12 A That's not how I interpret this. I think
13 if you have a designation for a patient that they
14 have chronic pain, and you prescribe opioids to them,
15 that doesn't mean that you're prescribing them
16 chronically. So even here, the CDC states that:

17 "The plan of initiating opioids to somebody
18 who has chronic pain should include discontinuing
19 those opioids if benefits do not outweigh risks. And
20 that they should continue only if there is clinically
21 meaningful improvement in pain and function that
22 outweighs risks to patient safety."

23 Which means you would have to have a very
24 good way of measuring whether that was true.

1 Q Doctor, despite all the words you just
2 used, I don't think we're disagreeing at all. My
3 question is simply: Is the CDC recommendation that
4 opioid therapy is one of the potential therapies for
5 chronic pain, isn't that part of this recommendation?

6 MR. ARBITBLIT: Objection. Object to
7 the prelude.

8 MR. PYSER: You can strike the
9 prelude. The question stands.

10 A I think the CDC recommendations have to be
11 looked at in the broader context of tens of millions
12 of Americans with chronic pain already being
13 prescribed opioids.

14 Q Well, this is -- Doctor, aren't we talking
15 about here before starting opioid therapy? So these
16 are new opioid therapies for chronic pain, correct?

17 A Yes, and I think the CDC --

18 Q Let me ask you the question. The CDC
19 states what clinicians should do before starting
20 opioid therapy for chronic pain, correct?

21 A Yes.

22 Q Okay. And, Doctor, I'll represent to you
23 that this document, the CDC recommendations, are
24 dated from 2016. Just so we have a record on it.

1 A Okay. Great. If I could just add one
2 thing that, you know, when you say does the CDC
3 recommend opioids for chronic pain, I would disagree
4 with that. Recommend implies that they think that
5 opioids are a good treatment for chronic pain, and I
6 don't believe that this is what these guidelines are
7 saying.

8 Q Are you familiar with a letter from the
9 American Medical Association criticizing the CDC's
10 Guidelines on opioid therapy?

11 A Yes.

12 Q Okay. And you discussed that in your
13 report at pages 82 and 83, correct?

14 A Yes.

15 Q And the AMA position is that patients
16 suffering from chronic pain can benefit from taking
17 opioids in dosages that may be greater than the CDC
18 Guidelines; is that right?

19 A Yes, that is what they assert.

20 Q Okay. And do you disagree with the
21 position of the American Medical Association?

22 A Yes, because they provide no evidence to
23 support that claim, contrary to the voluminous
24 evidence that are contrary to that claim.

1 Q Dr. Lembke, the letter that was submitted
2 by the American Medical Association to the CDC on
3 June 15th, 2020, advocating revisions to their
4 CDC -- 2016 guidelines for opioid use, are you
5 familiar with the authors of that letter?

6 A I probably know some of them, yes, but I
7 can't recall any specific names.

8 Q Do you know who James Madara is, a doctor
9 for the American Medical Association?

10 A No.

11 Q Is the American Medical Association a well
12 respected organization in the medical community?

13 MR. ARBITBLIT: Objection.

14 A I would say it's mixed.

15 Q Are you a member of the American Medical
16 Association?

17 A No.

18 Q So we've got the AMA taking one position,
19 the CDC taking a different position, you have your
20 position about which of them is correct, the VA has a
21 position. Is it fair to say there's some debate
22 within the medical community as to the appropriate
23 prescribing of opioids?

24 MR. ARBITBLIT: Objection.

1 A I think that the debate is really more
2 around what to do now, given the iatrogenic harm
3 that's already been done. I don't think there's
4 debate about whether or not opioids really work for
5 chronic pain. I think there is consensus that they
6 don't for the vast majority of people. And I don't
7 think there is debate about whether or not opioids
8 are highly addictive, even when prescribed by a
9 doctor. There is consensus that we have a huge
10 public health problem, an opioid addiction and
11 overdose problem caused by overprescribing.

12 The debate is around what to do with the
13 tens of millions of people who are already dependent
14 and addicted and how to solve that problem.

15 Q Do you agree that the nation no longer has
16 a prescription opioid driven epidemic?

17 MR. ARBITBLIT: Objection.

18 A I disagree. I disagree.

19 Q Okay. So if the AMA stated that, you
20 disagree with that, correct?

21 A Yes, I would disagree with that.

22 Q Do you agree that the CDC's approach fails
23 to balance needs for a comprehensive pain management
24 service, including access to non-opioid care, as well

1 as opioid analgesics when clinically appropriate?

2 MR. ARBITBLIT: Objection.

3 A I agree that the CDC guidelines did not
4 address that in their original guidelines, those
5 issues raised, and those are real issues and worth
6 debating.

7 Q And those issues are still being debated,
8 appropriate use of opioids, correct?

9 A No, the issues I was referring to that are
10 still being actively debated are what to do with the
11 population of individuals already opioid dependent
12 who can't get off; and also, what to do -- sorry. I
13 lost my train of thought. I had another important
14 point. But it will come back to me.

15 Q I want to make sure we're clear --

16 A Oh, yeah. Sorry. Sorry. I remembered.
17 And also what to do about, you know, the millions of
18 Americans who struggle with excruciating,
19 debilitating pain, which is also something that I
20 really care about.

21 Opioids are not the answer, but we need to
22 address that problem as well. And so there's concern
23 and debate, which is appropriate and justified about
24 how to do that currently.

1 Q Does the rate of suicide among patients who
2 were taking opioids but can no longer fill their
3 prescriptions concern you?

4 MR. ARBITBLIT: Objection. Assumes
5 facts not in evidence.

6 A My understanding is that one of the biggest
7 risk factors for suicide in this country is
8 possession of an opioid prescription, because it's a
9 direct lethal means.

10 Q And are you familiar with cases where
11 doctors or pharmacies refuse to fill prescriptions
12 and patients then committed suicide?

13 MR. ARBITBLIT: Objection.

14 A I have read about that in the lay press,
15 and I think that's terrible, you know, and we need to
16 be concerned about that as well. But continuing to
17 dispense opioids in high volume to individuals who
18 have developed opioid related problems is not, you
19 know, not the answer. We need to think about other
20 ways to help those individuals.

21 Q So balancing all of these issues, would you
22 agree that cutting off the supply of opioids today is
23 not a reasonable step to take?

24 MR. ARBITBLIT: Objection.

1 A Again, it depends on the case circumstance.
2 But I would agree, I would agree, that cutting off
3 the supply immediately to individuals who have become
4 physiologically dependent and need to be tapered
5 slowly is not the answer.

6 And to that end, I have created a protocol
7 called the BRAVO Protocol to educate physicians about
8 how to humanely and compassionately taper
9 opioid-dependent patients down to safer doses or off
10 altogether. So I've been active in that arena trying
11 to help solve that problem.

12 Q Move to strike as nonresponsive.

13 Dr. Lembke, do you believe there is a
14 percentage reduction in opioid shipment today that
15 would be appropriate?

16 A As I said before, I think we need to at
17 least return to early 1990s levels of prescribing.
18 And even then, I think we should look at what other
19 countries are doing. We're prescribing far more
20 opioids than any other country in the world, and I
21 think we could look at how they're managing pain in
22 order to figure --

23 Q Dr. Lembke, you're now talking about
24 prescribing. My question was: Do you believe there

1 is a percentage reduction in the distribution of
2 opioids that should be enacted today?

3 MR. ARBITBLIT: Objection. Object to
4 cutting off the witness during her answer.

5 A I think that those distribution rates
6 should go down to the rates at least of distribution
7 in the early 1990s and maybe even further based on --

8 Q --

9 MR. ARBITBLIT: You're doing it again.
10 Just be a little patient.

11 BY MR. PYSER:

12 Q So that would be 20 to 25 percent of
13 current distribution rates; is that right?

14 A I don't really see it as my role to put a
15 specific percentage on it. What I can relay is from
16 an historical experience that spans my career. I
17 think other experts will give you numbers, if that's
18 what you're looking for.

19 Q So, Dr. Lembke, if we returned to the rates
20 of distribution in the early 1990s, you've testified
21 earlier that that's approximately 20 to 25 percent of
22 current distribution rates. So that would mean that
23 for every four pills shipped today, a distributor
24 would only ship one; is that right?

1 A I really don't want to give a specific
2 number, because I think it involves calculating
3 variables like growth in the population, you know, an
4 aging population. But the bottom line is, we're
5 shipping too many opioids and we need to ship less.

6 Q Well, Doctor Lembke, if someone who teaches
7 an addiction medicine at Stanford and has been paid
8 hundreds of thousands of dollars by the plaintiffs in
9 this case can't say what the appropriate level of
10 opioid distribution in this country today is, who
11 can?

12 MR. ARBITBLIT: Objection. Instruct
13 you not to answer. Argumentative. Frame a proper
14 question and I'll let her answer.

15 I'm instructing you not to answer.

16 BY MR. PYSER:

17 Q Dr. Lembke, are you going to follow your
18 counsel's advice?

19 A Yes, I am.

20 Q Dr. Lembke, who would you recommend makes
21 the determination of what the appropriate level of
22 shipment of opioids should be in the United States?

23 A I don't really know specifically. I think
24 it should be people who have thought long and deep

1 about this problem, who have reviewed the best
2 evidence, who are aware of the public health crisis
3 wrought by distributors' actions, taking all of that
4 into account.

5 Q And, Dr. Lembke, have you thought at all
6 about what would happen if distributors only shipped
7 at the level of the early 1990s, if beginning
8 tomorrow distributors refused to ship more than
9 25 percent of today's shipments?

10 MR. ARBITBLIT: Objection.

11 A So I have never said that it should happen
12 beginning tomorrow. That would be as bad as cutting
13 off opioid dependent patients and not helping them
14 taper. We have to help distributors taper as well.
15 They're also dependent, and we have to help them with
16 their dependency.

17 Q How long do you believe it should take for
18 this country to get to what you claim is the
19 appropriate level of 20 to 25 percent of today's
20 opioid prescribing?

21 MR. ARBITBLIT: Objection.

22 A I think it's on the order of years. It
23 will take time. It's not something that's going to
24 happen tomorrow.

1 Q Dr. Lembke, again, to ask you a personal
2 question -- and counsel is free to mark it
3 confidential, have you ever personally taken opioids?

4 MR. ARBITBLIT: Objection.

5 A I have taken opioids -- I've been
6 prescribed or received opioids in the context of a
7 vocal chord surgery, so administered in the hospital,
8 which is why my voice is scratchy.

9 Q And you were prescribed them. Did you take
10 the opioids as part of your surgical treatment?

11 A They were administered to me. It wasn't
12 that I voluntarily took them. I can tell you more
13 about that conversation if you want to hear it.

14 Q So was it intravenous opioid administration
15 during a surgery; is that right?

16 A That's correct.

17 Q Was it fentanyl, the substance that was
18 administered?

19 A Yes.

20 Q Were you also prescribed any pills after
21 the surgery to take home with you?

22 A No.

23 MR. ARBITBLIT: No need to mark it
24 then.

1 Q Any other time that you've been prescribed
2 opioids, other than that surgical procedure?

3 A Well, I've given birth many times, and I
4 have received opioids in the context of delivering.

5 Q When you say in the context of delivering,
6 do you mean during birth, as in a local anesthetic?

7 A I have received a small dose of opioids
8 while delivering a baby. Just in the context of
9 delivering a baby, and not before and not after.

10 Q Okay. You have not been prescribed opioids
11 to take home with you after delivery?

12 A No.

13 Q And are you familiar with the fact that
14 many women are prescribed opioids after C-section
15 procedures in a pill form to take home?

16 A Yes.

17 Q Do you believe that's appropriate medical
18 treatment, to prescribe opioids following a
19 C-section?

20 A Not without very careful monitoring
21 stewardship and limited doses for short duration.

22 Q Do you believe under current guidelines for
23 obstetrics and gynecology appropriate procedures are
24 followed, or do you believe that opioids are

1 overprescribed for Caesarean sections today?

2 MR. ARBITBLIT: Objection. Compound.

3 A I don't think I've looked specifically at
4 the data on opioid prescribing for Caesarean section
5 per se. I have looked at data on opioid prescribing
6 in gynecologic surgery more broadly. The evidence is
7 clear that they are overprescribed in that context,
8 and that when doctors have cut back on prescribing in
9 that context, they've seen improved outcomes. And
10 also, importantly, patients have not reported having
11 more trouble with post-operative pain.

12 Q And do you believe opioids are
13 overprescribed in obstetrics through today? Is that
14 true today?

15 A I think that's still true today. Not in
16 all instances, but in many instances. I think there
17 is an active movement to try to pull back on
18 prescribing, which is appropriate.

19 Q Let's take a look, if we could, at
20 Exhibit 18.

21 And I'd like you to look in particular --
22 Exhibit 18 is the State of West Virginia Board of
23 Medicine Policy on Chronic Use of Opioid Analgesics.
24 Do you see that?

1 A Yes.

2 Q And it was adopted on September 11th, 2017?

3 A Okay. Yes. I see that.

4 Q Okay. Let's go to page 15, in the
5 conclusion.

6 A Yes.

7 Q And the third bullet point of the
8 conclusion reads:

9 "Adequate attention to patient education
10 and informed consent: The decision to begin opioid
11 therapy for chronic pain is a shared decision of the
12 clinician and patient after a discussion of the risks
13 and a clear understanding that the clinical basis for
14 the use of these medications for chronic pain is
15 limited, that some pain may worsen with opioids, and
16 taking opioids with other substances, such as
17 benzodiazepine, alcohol, cannabis, or other central
18 nervous system depressants; or certain conditions
19 such as sleep apnea, mental illness, pre-existing
20 substance use disorder, may increase risks."

21 Did I read that correctly?

22 A Yes, you did.

23 Q Do you agree or disagree with that policy
24 of the West Virginia Board of Medicine?

1 MR. ARBITBLIT: Objection.

2 A As long as the decision-making is informed
3 by real evidence, I think it seems reasonable.

4 Q Are you familiar with the West Virginia
5 Legislature's creation of the Coalition on Chronic
6 Pain Management?

7 A Yes.

8 Q Take a look at Exhibit 19. And if you look
9 at Exhibit 19 on the first page, there's a section,
10 Overview of the Legislation. Do you see that?

11 A Which page?

12 Q The very first one.

13 A Yes, I see that.

14 Q And it states in the third line:

15 "The coalition shall review the State's
16 chronic pain regulations and attempt to strike a
17 balance between regulation patient needs and clinical
18 judgment of physicians." Do you see that?

19 A Yes.

20 Q And I want to look now at page 4 of this
21 document, the recommendations of the coalition on
22 chronic pain management. And this is a document you
23 may recall you cited in your report.

24 Do you recall that?

1 A I'm sorry. Could you repeat that? Where
2 are we in this document?

3 Q Sure. We're looking at page 4. I was
4 directing you there. But separate question. Do you
5 recall citing this document in your report?

6 A Yes, I do.

7 Q Okay. And among the findings of the
8 coalition was a recommendation to the West Virginia
9 Legislature, that's SB-273, that's:

10 "Senate Bill 273 has inadvertently and
11 inappropriately interfered with the
12 patient/practitioner relationship, unnecessarily
13 regulating the evidence-based practice of medicine,
14 and in some cases even dissuade physicians who
15 deliver safe, legal, and necessary medical care to
16 patients suffering from pain. In addition, in some
17 cases pharmacists have been dissuaded to dispense
18 safe, legal, and necessary medications to patients as
19 part of proper medication therapy management."

20 Do you agree with that finding of the
21 Coalition on Chronic Pain Management?

22 MR. ARBITBLIT: Objection.

23 A I don't agree with all of it, no.

24 Q Do you have concerns that some of the laws

1 restricting prescribing and dispensing of opioids
2 have, as the Coalition found -- excuse me -- yeah,
3 the Coalition found, quote, "Inadvertently and
4 inappropriately interfered with the
5 patient/practitioner relationship"?

6 MR. ARBITBLIT: Objection.

7 A No.

8 Q What about that statement do you disagree
9 with?

10 A I disagree with that part of it. I don't
11 think that it inappropriately interfered with the
12 patient practitioner relationship. I think that was
13 appropriate.

14 Q And on the front page of the Coalition on
15 Chronic Pain Management's report to the legislature,
16 there's a listing of individuals who made up the
17 Coalition. Do you see that membership?

18 A Yes, I do.

19 Q And have you spoken to any of the
20 individuals who were part of the Coalition on Chronic
21 Pain Management?

22 A No.

23 Q Are you aware that the Stanford Pain
24 Management Center developed a free online course in

1 conjunction with the American Academy of Pain
2 Medicine?

3 A Yes, I was aware of that.

4 Q Have you reviewed that course?

5 A Parts of it, yes.

6 Q Are you familiar with the content of the
7 course?

8 A I think so, yeah.

9 Q Is the Stanford Pain Management Center's
10 course reliable?

11 MR. ARBITBLIT: Objection.

12 A So I would want to rereview it more
13 carefully, but -- in order to be able to answer that,
14 but my recollection is that some of the same
15 misleading messages were in that course -- some of
16 the same misleading messages that I talk about in my
17 report were in that course.

18 Q Okay. And what steps did you take to
19 correct what you believe are misleading messages that
20 are being disseminated by the Stanford Pain
21 Management Center?

22 A Well, I wrote a book about it.

23 Q Did you go to the Stanford Pain Management
24 Center and say, "As your colleague, I think you're

1 making a mistake"?

2 A Yes, I have done that many times. I talk
3 frequently with my colleagues. I have a courtesy
4 appointment in that department. I debated my
5 colleagues in public forums on this issue.

6 Q And who are the colleagues with whom you've
7 debated about this issue who disagree with you?

8 A Sean Mackey.

9 Q And is that Dr. Mackey?

10 A Yes. We don't disagree on all issues. But
11 we do disagree on some.

12 Q What do you and Dr. Mackey disagree about?

13 A At this point it's been some time since
14 I've spoken to him about it, so I would probably have
15 to go back. I wouldn't want to misrepresent his
16 views.

17 Q Sitting here today, can you recall any of
18 the subjects on which you and Dr. Mackey disagree?

19 A I would really want to review. You could
20 also review a panel discussion that he and I had.
21 It's available to be viewed online. You can see
22 that.

23 Q Can you help me out? Where is that
24 available to view online, if you recall?

1 A Stanford's Public Health Policy Forum.
2 It's in my CV. I could look at my CV and find the
3 exact date. I believe those are available for
4 viewing online.

5 Q We'll take a look at that.

6 Back when you were a medical student at
7 Stanford, did your professors teach you that opioids
8 should be prescribed to treat pain?

9 A Yes.

10 Q Do you believe your professors were acting
11 in bad faith when they made that recommendation to
12 you?

13 MR. ARBITBLIT: Objection.

14 A What do you mean by "in bad faith"?

15 Q Do you think that they had bad motives, or
16 do you think they were just expressing what their
17 understanding of best practices was at the time?

18 MR. ARBITBLIT: Objection.

19 A I think they were mostly well-intentioned
20 expressions, what they had been taught themselves.

21 Q Does the Stanford University Medical School
22 still teach that opioids are indicated for the
23 treatment of chronic pain?

24 A There is ongoing discussions and changing

1 of the way that we're teaching opioid prescribing to
2 enlighten students about the fact that benefits were
3 overstated, and that the risks are significant. And
4 I and my pain colleagues have collaborated together
5 to do that. We have consensus on that material.

6 Q Has that change been enacted as of today,
7 September 17, 2020?

8 A Yes.

9 Q When was that change enacted, to change the
10 way that Stanford University Medical School students
11 are taught about the treatment of chronic pain with
12 opioids?

13 A So I was appointed along with one of my
14 pain colleagues to a task force -- I'm not
15 remembering the exact year, it is in the report -- to
16 look at that very problem and to do a better job
17 educating our students about responsible opioid
18 prescribing.

19 Q Do you remember --

20 A I have led that task force with colleagues
21 since that time. And the curriculum continues to be
22 improved upon.

23 Q Do you recall approximately when you
24 started that process of improving the curriculum as

1 to treatment of chronic pain with opioids?

2 A I'm looking at my CV now. Here we go.

3 "Since 2016," this is page 2 of my report,
4 "I have chaired the Addiction Medicine Task Force.
5 The goal of the task force is to reevaluate and
6 recreate the medical school curriculum on addiction
7 and safe prescribing."

8 Q So these changes to the curriculum to
9 educate medical students to prescribe less opioids,
10 would you say that began in 2016 with your
11 appointment there?

12 A I think that's when they really gained
13 momentum. I would say I have been making efforts
14 well before then to educate students, trainees,
15 colleagues. And I wasn't alone in that, obviously.
16 There are many other people who have been, you know,
17 working on that project.

18 Q Is it true that, let's say, in 2015 and
19 before, Stanford University medical students were
20 likely taught that opioids were indicated as a
21 treatment for chronic pain?

22 A Yes.

23 Q So going back to your report at page 62,
24 you have an Opinion No. 6. -- sorry, Doctor. Bear

1 with me one minute.

2 MR. PYSER: You know what, we've been
3 going about an hour. Why don't we take a break now.

4 THE DEPONENT: Okay.

5 MR. PYSER: Can we go off the record,
6 please?

7 VIDEOGRAPHER: The time is 4:41.
8 We're now going off the record.

9 (A recess was taken.)

10 VIDEOGRAPHER: The time is 4:51.
11 We're now back on the record.

12 BY MR. PYSER:

13 Q Dr. Lembke, in your prior reports when you
14 spoke about manufacturer marketing, did you quantify
15 how much money was spent on manufacturer marketing?

16 A No.

17 Q Did you look at all about how much money
18 was being spent on marketing by manufacturers for
19 opioids?

20 A My understanding is it's billions of
21 dollars.

22 Q And do you think one way to measure part of
23 the influence on prescribing would be to look at how
24 much money individual companies are spending on

1 marketing efforts?

2 A That might be one direct method of looking
3 at it.

4 Q I'm going to show you, Dr. Lembke, a
5 document that we just received from your counsel last
6 night as one of your materials considered. So
7 obviously we couldn't put it in your box, because we
8 didn't have it yet.

9 So, Brad, if you could bring up Exhibit 33.

10 MR. MASTERS: One second. My machine
11 is a little slow.

12 MR. PYSER: No problem.

13 Q If it's going to take a while, Brad, we can
14 move on and come back to it -- oh. There it is.

15 Okay.

16 BY MR. PYSER:

17 Q Dr. Lembke, is this one of the studies that
18 you looked at recently?

19 A Yes.

20 Q Do you recall when you first looked at this
21 document for purposes of its inclusion in your
22 Materials Considered for this case?

23 A It was some time ago.

24 Q Approximately how long ago? Six months,

1 more, less?

2 A Probably more.

3 Q A year ago?

4 A When did it come out?

5 Q Let's see if we can zoom in on it.

6 November 11, 2013.

7 A Yeah, I think it's been years ago since I
8 looked at this. And then I've looked at it again
9 since I'll go back to an article multiple times.

10 Q And you think you looked at it for purposes
11 of this case about six months ago; is that right?

12 MR. ARBITBLIT: Objection.

13 A I don't remember exactly when I looked at
14 it.

15 Q Do you think you looked at it more than a
16 month ago? Just rough approximation for me, if you
17 could, Dr. Lembke.

18 MR. ARBITBLIT: Objection.

19 A I know I have looked at this and I have
20 read this article. And I don't remember the last
21 time that I reviewed it. I'm sorry.

22 Q Do you think it was more than a week ago
23 when you last reviewed it?

24 MR. ARBITBLIT: Objection.

1 A Yes.

2 Q Dr. Lembke, I want to direct your attention
3 to that pie chart on the first page that looks at the
4 expenditures by type of pharmaceutical marketing in
5 2012. Do you see that?

6 A Yes.

7 Q And in 2012 overall, this article or study
8 finds that there were \$27 billion spent in
9 pharmaceutical marketing. Do you recall that?

10 A Yes.

11 Q Okay. Do you know how much, if any, of
12 that \$27 million was spent by the three Distributor
13 Defendants here?

14 A No.

15 Q Did you review any of the references at the
16 end of the article to see if the source material
17 included distributors at all in its calculation of
18 marketing?

19 A I may well have done that. I don't
20 remember specifics.

21 Q Sitting here today, do you know if a single
22 penny of that \$27 billion came from any of the
23 defendants here?

24 A I don't know.

1 Q Do you know what detailing is, in terms of
2 doctors, when a pharmaceutical marketer -- excuse me.
3 Strike that. When a pharmaceutical manufacturer
4 details a doctor, do you know what that means?

5 A Yes.

6 Q What is detailing of a doctor?

7 A Detailing is when representatives of the
8 opioid industry go to doctors' offices, or the places
9 where doctors work and target both doctors and their
10 staff with promotional material to promote
11 prescribing of their products.

12 Q Didn't mean to cut you off there, Doctor.
13 I want to be clear about who we're talking about
14 here. Are you aware of any doctor detailing
15 performed by any of the three distributor defendants
16 that are in this case?

17 A I am aware of a collaboration between
18 McKesson and Janssen that involved the promotion of
19 Nucynta coupons, that involved also direct detailing
20 to promote those coupons. Those coupons are being
21 disseminated by McKesson.

22 Q Are you aware of any employee of McKesson
23 who detailed any doctor in the United States as part
24 of that program?

1 A Well, those detailers who were promoting
2 those coupons were effectively working for McKesson.

3 Q Doctor, can you name any McKesson employee
4 who visited a doctor's office?

5 A Well, I think I just answered that.

6 Q No, I don't think you did, Doctor.
7 Dr. Lembke, are you aware of any visiting of doctors'
8 offices by McKesson employees?

9 A I'm aware of employees of Janssen visiting
10 doctors' offices around a coupon that was created by
11 McKesson.

12 Q Okay. Again, are you aware of any McKesson
13 employee visiting doctors' offices?

14 A No.

15 Q And are you aware of any AmerisourceBergen
16 Drug Corporation employee visiting doctors' offices
17 as part of an effort to detail doctors?

18 A No.

19 Q And are you aware of any Cardinal Health
20 employee visiting doctors' offices as part of an
21 effort to detail doctors?

22 A No.

23 Q Dr. Lembke, I want to direct your attention
24 to page 78 of your report, and in particular,

1 paragraph G on page 78. Are you with me, Doctor?

2 A Yes.

3 Q Okay. And in paragraph G on page 78 of
4 your report, Exhibit 1, you refer to the SPACE
5 Randomized Clinical Trial?

6 A Yes.

7 Q And the SPACE Randomized Clinical Trial
8 published in 2018 was the first long-term randomized
9 controlled trial of opioids for the treatment of
10 moderate to severe pain; is that right?

11 A Yes.

12 Q And, in fact, you don't cite any studies
13 published prior to 2013 that suggest that opioids are
14 not more effective than non-opioids for treating
15 pain, correct?

16 MR. ARBITBLIT: Objection. Vague.
17 Confusing. Double negatives.

18 MR. PYSER: -- double negatives, so
19 I'll rephrase the question.

20 BY MR. PYSER:

21 Q Dr. Lembke, are you aware of any studies
22 published prior to 2013 that suggest that non-opioid
23 treatment is more effective than opioids for treating
24 pain?

1 A I'm aware of studies showing that
2 non-opioids and opioids are comparable, and opioids
3 have significantly more harm, but I can't right now
4 recall a study specifically addressing what you just
5 said.

6 Q Okay. And the SPACE trial, as a long-term
7 randomized controlled trial, is that the gold
8 standard for study design to test effectiveness?

9 A Yes.

10 Q Dr. Lembke, in your opinion, by what year
11 did it become clear to a reasonable degree of medical
12 certainty that opioids were not more effective than
13 non-opioid treatments for treating chronic pain?

14 A I think that -- I think that's been known
15 for probably a hundred years.

16 Q So it's your view that for a hundred years,
17 doctors have known that non-opioid treatments are
18 more effective for treating chronic pain than opioid
19 treatments?

20 MR. ARBITBLIT: Objection.

21 A I'm sorry. Could you rephrase the
22 question?

23 Q Let's go back to the original, to make sure
24 we're on the same page.

1 A Okay.

2 Q By what year would you say in your opinion
3 it became clear to a reasonable degree of medical
4 certainty that -- strike that. Let me rephrase the
5 question, because I think we've got some double
6 negatives that are catching us up a little bit.

7 So, Dr. Lembke, by what year would you say
8 it became clear to a reasonable degree of medical
9 certainty that non-opioid alternatives were more
10 effective than opioids for treating chronic pain?

11 MR. ARBITBLIT: Objection.

12 A I'm not -- I think that most of the data
13 show that medications in general, whether opioids or
14 non-opioids, are not particularly effective at
15 treating chronic pain. So I think I disagree with
16 the premise of your question.

17 Q So the SPACE Randomized Controlled Trial
18 found no benefit of opioids over non-opioid
19 medication in 2018, correct?

20 A That's correct.

21 Q And up until that point --

22 A Actually, let me qualify that. Sorry. I
23 think that non-opioids performed slightly better than
24 opioids in terms of pain intensity for the SPACE

1 trial.

2 Q So in the SPACE trial, non-opioids
3 prescribed -- strike that. So in the SPACE trial,
4 non-opioids performed better than opioid medication
5 in the treatment of moderate to severe pain, correct?

6 A Yes.

7 Q And was that a new finding in 2018?

8 MR. ARBITBLIT: Objection.

9 A I can't recall right now whether there was
10 other head-to-head studies. Certainly, there are no
11 other studies that went out for a whole year in a
12 sample population that was very similar to the types
13 of patients we actually see in the real world.

14 Q So in what year did it become clear that
15 non-opioids were as effective as opioids in the
16 treatment of moderate to severe pain?

17 MR. ARBITBLIT: Objection.

18 A Yes, so I guess I'm not comfortable with
19 the way you framed the question, because it implies
20 that non-opioids are effective, it potentially
21 implies that opioids are effective, and that one is
22 better than the other. The truth is, neither one
23 works very well in the treatment of chronic pain.

24 Q But if we're just comparing the two,

1 non-opioid pain treatment -- and to be clear, when
2 we're talking about non-opioids, we're talking about
3 acetaminophen, correct? Is one?

4 You have to speak so the court reporter can
5 take down your words.

6 A Yes. Yes, I'm sorry. Yes. That's right.
7 Acetaminophen is one.

8 Q Ibuprofen would be another example?

9 A Yes.

10 Q Can you name for me some other non-opioid
11 pain treatment medications?

12 A Ox2 inhibitors, duloxetine, gabapentin.

13 Q There is an array of non-opioid pain
14 treatments available, correct?

15 A Yes. Uh-huh. Yes.

16 Q And prior to the SPACE Randomized Clinical
17 Trial study, have there been any other randomized
18 clinical trial study that had compared opioids versus
19 non-opioids for the treatment of moderate to severe
20 pain that you're aware of?

21 A I'm not aware of any other studies that
22 compare non-opioids and opioids that went out 12
23 months.

24 Q Dr. Lembke, today, do you know what

1 percentage of opioid prescriptions are written for
2 pain related to cancer?

3 A I think you asked me this already, and I
4 said no.

5 Q You don't know?

6 A That's right.

7 Q Okay. My apologies if I asked it already.

8 Do you know what percentage of opioid
9 prescriptions today are written for post surgical
10 pain?

11 A No.

12 Q Do you know what percentage of opioid
13 prescriptions today are written for chronic pain
14 conditions?

15 A No, although I do know that that percentage
16 has been steadily increasing over the past three
17 decades.

18 Q And has the percentage of prescriptions
19 written for chronic pain continued to increase more
20 recently, say over the last five years?

21 A I think over the last five years there is
22 some decrement, but it really depends on where in the
23 United States you are talking about. It varies
24 county to county.

1 Q Do you know, Doctor, what percentage of
2 opioid prescriptions are written for dental
3 procedures, like tooth extractions?

4 A No.

5 Q Doctor, do you have an opinion one way or
6 the other whether Medicaid should pay for opioid
7 prescriptions?

8 MR. ARBITBLIT: Objection.

9 A Medicaid is, you know, an insurance
10 company. They should pay for treatment once it's
11 medically indicated to do so.

12 Q And how should an insurance company, like
13 Medicaid decide whether a particular opioid
14 prescription is medically indicated?

15 MR. ARBITBLIT: Objection.

16 A They should weigh the evidence.

17 Q And when looking at an individual opioid
18 prescription, how should an insurance company weigh
19 the evidence to decide whether to pay for that
20 prescription or not?

21 MR. ARBITBLIT: Objection.

22 A One of the factors would be what the
23 indication was, how much opioids were being
24 prescribed, in what context.

1 Q Any other information that would be useful
2 that you can think of?

3 A That's sort of what I can think of now.
4 It's been a long day.

5 Q Fair enough. Are you aware that one
6 recommendation to limit the use of opioids has been
7 to limit payment by insurance companies for opioid
8 use?

9 A Yes.

10 Q Do you support that recommendation?

11 A I support that recommendation with caveats.

12 Q What are those caveats?

13 A Making sure that patients who are dependent
14 on prescription opioids have enough time to taper
15 down to lower, safer doses, and making sure that
16 patients have at least some access to other
17 treatments for pain. And that patients who have
18 become addicted to prescription opioids have access
19 to treatment for opioid addiction.

20 Q Dr. Lembke, you mentioned earlier today
21 having read in the popular press some stories about
22 patients struggling with limited access to opioids.
23 Do you recall that?

24 A Yes.

1 Q Take a look at Exhibit 21, if you could.

2 So taking a look at your copy of
3 Exhibit 21, is that a New York Times story?

4 A Yes, it is.

5 Q And it's titled "When the Cure is Worse
6 Than the Disease," and the subtitle is, "In an effort
7 to reduce opioid addiction, doctors are cutting back
8 on pain medication and sometimes leaving patients to
9 suffer."

10 Did I read that correctly?

11 A Yes.

12 Q Do you agree with the premise of the
13 article that -- phone interruption noise --

14 (Court reporter asked for clarification)

15 Dr. Lembke, do you agree with the premise
16 of the article that in an effort to reduce opioid
17 addiction, doctors are cutting back on pain
18 medication and sometimes leaving patients to suffer?

19 A So I have spoken on this issue. My BRAVO
20 Protocol, which is in the appendix, intended to
21 address this issue, which is that patients who have
22 become psychiatrically dependent on opioids should
23 not be abruptly cut off from those opioids, but
24 rather helped to taper to safer doses, or to get off

1 entirely. And that the phenomenon of patients having
2 difficulty finding doctors to help them with that is
3 a real phenomenon.

4 Q And it's not just patients who need to
5 taper off. Isn't it true there are also certain
6 diseases, like interstitial cystitis -- I'm going to
7 say this wrong --

8 A Interstitial cystitis.

9 Q Thank you. Isn't it the case that there
10 are conditions, like the one you just mentioned,
11 interstitial cystitis, that require pain management
12 treatment from doctors?

13 MR. ARBITBLIT: Objection.

14 A Yes. Let's go to -- in order to be able to
15 answer that, I'd like to go to Appendix IV on the
16 Proper Indications for Opioids. This is a document
17 that I wrote, addressing the question when opioids
18 should be used.

19 Q Okay. I'm with you at page 253 of
20 Exhibit 1?

21 A Yes.

22 Q Okay.

23 So, Madam Court Reporter --

24 A If you go to page 260, you will see the

1 section Opioid Use for Specific Painful Disease
2 States.

3 Q Okay.

4 A I'm reading from my report:

5 "Opioids are indicated for treatment of
6 certain painful diseases, for example, sickle cell
7 crisis and post-herpetic neuralgia, end-of-life
8 suffering, and hospice care. Opioids are indicated
9 for cancer pain based in significant part on the
10 expectation that cancer patients have a limited life
11 expectancy, and that the risk of opioid use disorder
12 and mortality are outweighed by the benefits of pain
13 relief.

14 "However, with advance treatment methods,
15 more cancer patients are surviving for longer periods
16 of time, and the risk of addiction and overdose
17 mortality among cancer patients have been identified
18 in the peer-reviewed medical literature. Thus, even
19 in the setting of cancer pain, caution should be
20 exercised to treat with the lowest dose for the
21 shortest time and to treat with low dose opioids
22 intermittently rather than continuously to reduce the
23 risks of opioid use disorder and mortality."

24 Q Okay. So, Dr. Lembke, returning to my

1 question, which I think may be answered by just the
2 very first clause of the first sentence you read,
3 which is: Are there diseases, like interstitial
4 cystitis --

5 A I love that you can't say that. That makes
6 my day.

7 Q -- for which opioids are indicated for
8 treatment?

9 MR. ARBITBLIT: Objection.

10 A So I think taking that first sentence out
11 of context is not an entirely accurate
12 representation, because it's -- certainly you want to
13 add the later sentences, in which I say that caution
14 should be exercised to treat with the lowest dose for
15 the shortest time and to treat with low dose opioids
16 intermittently rather than continuously.

17 So when we talk about using opioids in the
18 treatment of pain, the key there is to use them
19 short-term and at low doses, not at high doses for
20 long duration, because that's really when the risks
21 outweigh the benefits.

22 Q Okay. But there are certain painful
23 diseases that you list in your report at Exhibit 1,
24 page 260, sickle cell crisis and post herpetic

1 neuralgia, where opioids are indicated for treatment,
2 correct?

3 A Yes.

4 Q Okay. Is the disorder for which I cannot
5 say the name -- interstitial cystitis -- one of those
6 disorders for which opioids are indicated?

7 A I'm not that familiar with that particular
8 disorder and the kinds of pain that people see with
9 that disorder.

10 Q How about patients with spinal cord
11 injuries who, even after multiple surgeries, have
12 chronic pain, is that a situation in which opioids
13 may be indicated?

14 A You know, unfortunately, the data are
15 pretty (indiscernible), that failed back syndrome,
16 which is a term for what you're describing, is a
17 situation in which opioid therapy long-term is not a
18 good idea.

19 And, again, I just want to emphasize, you
20 know, it's devastating, the pain that patients have
21 to experience. If opioids were the solution, I would
22 be more than happy to prescribe them, but they're
23 not. I think that's the problem.

24 Q How about systemic lupus, is that a disease

1 for which opioids can be indicated?

2 A So systemic lupus is an autoimmune disease
3 which manifests variably across patients. Some
4 people have very mild forms for which there is little
5 or no pain, and other people have severe,
6 debilitating, life-threatening forms. Those would
7 depend on the individual case. But, yes, there are
8 conditions in which opioids are indicated. I make
9 that very clear in my report. My point is that we
10 need to stop prescribing high doses for months to
11 years to decades. That's the harm.

12 Q Dr. Lembke, in your report, you refer to
13 something as The Gateway Effect. Do you recall that
14 term?

15 A Yes.

16 Q Are your opinions as to the Gateway theory
17 the same as those you offered in New York and Ohio?

18 A Yes.

19 Q Do you know, Dr. Lembke, what percentage of
20 people who are prescribed opioids become addicted to
21 prescription opioids?

22 A I think the Vowels study addresses that.
23 And that's in my report. The Vowels study estimates
24 that approximately 10 percent of patients receiving

1 opioids for a medical condition will go on to develop
2 a severe opioid use disorder and approximately 20 to
3 25 percent will develop what Vowels calls opioid
4 misuse, but which is effectively the equivalent to a
5 mild opioid use disorder.

6 Q And do you believe those statistics from
7 that study are accurate and reliable?

8 A Yes.

9 Q And when we talk about those prescribed
10 opioids, are you limiting that universe of people,
11 those prescribed opioids, if we go back to earlier in
12 the day when we put opioid prescriptions in three
13 categories -- we had the Lembke approved category;
14 the doctors operating in good faith, Category 2; and
15 Category 3 was instances where it's a pill mill, a
16 doctor is breaking the law. So the instances that
17 are being looked at there in the study you just
18 quoted, is that across all three categories, or is it
19 limited to people who received a legitimate
20 prescription? And by "legitimate," I mean in
21 Category 1 or 2?

22 MR. ARBITBLIT: Objection.

23 A Yes. So the VOLE (phonetic) study, there's
24 also the Boscarino study, those all look at patients

1 who are receiving legitimate opioid prescriptions for
2 a medical condition, and both of those studies
3 estimate that between 10 and 30 percent of the
4 patients will become addicted through a medical
5 prescription. And I think those are reliable
6 sources.

7 Q Do you know what percentage of people who
8 develop an opioid use disorder later begin using
9 heroin?

10 A So I cite -- I'm sorry. Can you just
11 rephrase the question? Can you restate the question?
12 Not rephrase, just restate.

13 Q I'll do my best. Dr. Lembke, do you know
14 what percentage of people with an opioid use disorder
15 based on prescription opioids later begin using
16 heroin?

17 A So the Lankenau study that I cite notes
18 that two-fifths of patients who began with a medical
19 prescription ended up as injection drug users,
20 primarily heroin.

21 Q I'm sorry, two-fifths of patients with
22 opioid use disorder? So --

23 A Yes, two-fifths of patients who were
24 injection drug users started with their own medical

1 prescription.

2 Q Okay. And do you know, of the patients who
3 are intravenous drug users, or heroin users, what
4 percentage of those individuals used alcohol before
5 they used heroin?

6 A Are you talking about using alcohol
7 recreationally, having alcohol use disorder -- I
8 mean, that's a broad category.

9 Q Alcohol use disorder.

10 A So what percentage -- If you could restate
11 the question.

12 Q What percentage of patients who later
13 develop a heroin use disorder had previously suffered
14 from an alcohol use disorder?

15 A I don't have specific numbers on that, no.

16 Q Do you have specific numbers on what
17 percentage of heroin users had previously used
18 alcohol in a recreational manner?

19 A No.

20 Q Do you have a percentage on what percentage
21 of heroin users had previously used marijuana in a
22 recreational manner?

23 A No.

24 Q Do you have a percentage of heroin users

1 who previously used methamphetamine in a recreational
2 manner?

3 A Could you describe what you mean by
4 recreational manner? I mean, Americans use alcohol
5 in a recreational manner. Many Americans use
6 cannabis in a recreational manner.

7 Q Let's go to methamphetamine. Would you
8 agree with me that any use of methamphetamine is
9 contrary to medical advice?

10 A No.

11 Q Would you agree with me that -- Are there
12 methamphetamines that are prescribed by doctors?

13 A Yes.

14 Q Would you agree with me that
15 methamphetamine not prescribed by a doctor is
16 contrary to medical advice, people shouldn't be using
17 methamphetamine unless prescribed?

18 A Yes.

19 MR. ARBITBLIT: Objection.

20 Q Do you know -- And would it be fair to say
21 that if you're using methamphetamine without a
22 doctor's prescription, would you call that illegal
23 use of methamphetamine? Can we agree on that term?

24 A Okay.

1 Q Do you know what percentage of heroin users
2 previously were illegal users of methamphetamine?

3 A No.

4 Q Doctor, I want to return briefly to the
5 last topic we were talking about where we were
6 talking about the percentage of patients prescribed
7 opioids who later develop an addiction or opioid use
8 disorder, okay?

9 A Okay.

10 Q And please correct me if I'm
11 misremembering. I believe you said that 10 to
12 30 percent of all patients who were prescribed
13 opioids later develop opioid use disorder; is that
14 right?

15 A Yes.

16 Q Okay. I just want to clarify. The patient
17 population you're talking about there, is that
18 limited to chronic pain patients?

19 A For the Boscarino study, the sample that
20 they took was a patient population sample who had
21 received, I believe, five or more prescriptions
22 within the year. I don't know whether or not they
23 specified chronic pain diagnosis, but they
24 extrapolated, given that number of prescriptions,

1 that the individual had chronic pain, because they
2 were given opioids chronically.

3 In the Vowels study, I believe that they
4 did limit it to a chronic pain population -- chronic
5 non-cancer pain population.

6 Q Okay. So your statistic that 10 to
7 30 percent of patients who develop opioid use
8 disorder -- excuse me. Strike that.

9 So your assessment that 10 to 30 percent of
10 patients prescribed opioids develop opioid use
11 disorder is based on one of two populations, either
12 chronic pain patients or those who received more than
13 five prescriptions for opioids within a single year,
14 correct?

15 A I believe it was five or more, but yes.

16 Q Okay. So in that 10 to 30 percent study,
17 it would not capture someone who, for example,
18 received a single prescription for opioids after a
19 Cesarean section, correct?

20 A It would not capture that, but I have in my
21 report other data regarding single exposure, for
22 example, the Schroeder study --

23 (Audio distortion ringtone alert
24 interference; court reporter asked for clarification)

1 -- yeah, other data looking at -- So first
2 of all, let me just say in response, it is possible
3 to become addicted to opioids after a single medical
4 prescription. I have seen that clinically, and there
5 are data in the literature to support that. And
6 those are in my report.

7 Q So, Dr. Lembke, do you have a percentage to
8 offer of the percentage of patients who suffer from
9 opioid use disorder after a single prescription for
10 opioids?

11 A I think that the data shows that it's about
12 6 to 10 percent of people will go on to develop an
13 opioid use disorder with a single exposure.

14 Q Okay. And where are you basing that 6 to
15 10 percent figure, from what?

16 A So that's based on Schroeder, et al -- I
17 can find it in my report -- as well as other studies
18 by Brummett, et al, and Delgado, showing persistent
19 opioid use after being treated with opioids for an
20 acute self-limiting injury.

21 Now, persistent opioid use is not the same
22 as addiction, but it certainly increases the risk of
23 addiction.

24 Q Okay. So in those studies are we limiting

1 the population to just those who have received a
2 single prescription, or is it a wider population,
3 including those who received a single prescription or
4 those who received many opioid prescriptions?

5 A The vast population, since you asked about
6 a single prescription, is limited to people who have
7 received a single prescription.

8 Q And it's not calculating those who end up
9 with opioid addiction or opioid use disorder. What
10 is the outcome that it's calculating? You just said
11 it. I want to make sure I'm clear?

12 A Well, for the Schroder study, it was
13 calculating how many people ended up with an opioid
14 use disorder, documenting in the medical record
15 within a year of being prescribed an opioid as part
16 of a dental procedure. The other studies are looking
17 at persistent opioid use, which is the scenario in
18 which a patient has an acute injury, is prescribed an
19 opioid, and a year later, or three years later in
20 some cases, is still being prescribed an opioid
21 presumably for the acute injury.

22 Q Do you know what year the Schroeder study
23 was published? I don't have it handy in your report.

24 MR. ARBITBLIT: Want my help, Steve?

1 MR. PYSER: In this rare instance,
2 yes, sir.

3 MR. ARBITBLIT: That's why I waited so
4 long to ask. If you look at page 53 of the Materials
5 Considered, Item 679 is the Schroeder study, 2018.

6 MR. PYSER: Thank you.

7 MR. ARBITBLIT: The first one is free.

8 MR. PYSER: Why don't we take about
9 five minutes. I'll likely be able to pass the
10 witness when we come back. I just want to check my
11 notes real quick.

12 VIDEOGRAPHER: The time is 5:34.
13 We're now going off the record.

14 (A recess was taken.)

15 VIDEOGRAPHER: The time is 5:40.
16 We're now back on the record.

17 MR. PYSER: Before passing the
18 witness, I just wanted to make the point that we're
19 going to hold this deposition open because of last
20 night's disclosure of new material. There's many
21 documents on that list that we haven't been able to
22 open yet, and certainly with a document delivered at
23 6:39 p.m. the night before a deposition, haven't been
24 able to analyze.

1 So with that on the record and
2 reserving our rights to come back to Dr. Lembke with
3 any questions on those, I'll pass the witness.

4 MR. ARBITBLIT: Before you go, I'll
5 just state, Steve, you're entitled to your position.
6 But I think in fairness, as we stated, the
7 witnesses -- the witness is under an obligation to
8 produce materials she's seen, and she met that
9 obligation, and so did we. And that with the
10 exception of one question when you asked her
11 specifically if she had knowledge of something, and
12 she offered that in response to a question, the
13 circumstances are, as we've stated, opinions are as
14 stated in the report and the materials provided and
15 listed, along with the report, are those that she
16 would rely on for her testimony. She was entitled to
17 answer honestly when you asked her a question about
18 knowledge of something that was in those new
19 documents.

20 So we represent to you that the
21 opinions she plans to offer at trial will not go
22 beyond the report, nor will it go beyond the
23 materials stated and the materials considered. So I
24 just want to make the record clear on that.

1 MR. PYSER: Well, I just want to
2 clarify what you just said, Counsel. When you say
3 the opinion won't go beyond the materials, maybe I
4 misunderstood your language. The materials stated.
5 Are you referring to the materials in the report, or
6 are you including the materials that we received last
7 night at 6:39 p.m. amongst the materials she may use
8 to form her opinions at trial?

9 MR. ARBITBLIT: I'm excluding the
10 materials that were on the list you received last
11 night. I'm limiting -- and the witness' testimony
12 will be limited, unless someone asks her a question
13 that's open-ended and calls for something that she
14 has to answer honestly, based on knowledge, which I'm
15 sure you would agree would be appropriate, but as
16 good lawyers you will be careful to ask her questions
17 that are within the bounds of the report.

18 And that's what she's planning to
19 testify to, the August 3rd report and the
20 August 3rd list of Materials Considered in support
21 of those opinions, not the documents that you
22 received last night.

23 MR. PYSER: I appreciate that
24 clarification, Counsel. I think we still have an

1 issue, and we reserve our right if we decide to go to
2 the judge and Special Master Wilkes to request more
3 time.

4 Okay. I believe Ms. Rodgers is up
5 next.

6 MS. RODGERS: Thank you.

7 EXAMINATION BY COUNSEL FOR MCKESSON:

8 BY MS. RODGERS:

9 Q Hi, Doctor. My name is Megan Rogers. I'm
10 with the law firm Covington and Burling and I'm
11 representing McKesson. I just want to --

12 (Audio distortions; court reporter asked for
13 clarification.)

14 VIDEOGRAPHER: The time is 5:44.
15 We're now going off the record.

16 (Pause)

17 VIDEOGRAPHER: The time is 5:45.
18 We're now back on the record.

19 MS. RODGERS: Okay. I was just saying
20 that at the outset, I wanted to join in Mr. Pyser's
21 reservation of rights before I forget at the end,
22 based on the -- (audio distortion) list of materials
23 preserved -- or Materials Considered. I understand
24 (audio distortion) Materials Considered -- I

1 understand your counsel's position on those, but
2 we're going to join with Pyser as to our rights to
3 that issue.

4 BY MS. RODGERS:

5 Q I want to turn back to your fifth opinion
6 in your report, and I'm not going to retread old
7 ground, but I want to start on page 53 and walk
8 through the seven specific instances in your report
9 where you allege that McKesson collaborated with
10 manufacturers.

11 So starting with romanette i, page 54, if
12 we could. The first such program is an alleged
13 partnership between McKesson and Janssen, related to
14 Duragesic. Do you see that in your report?

15 A Yes.

16 Q Thank you. And with respect to this
17 romanette i, you cite one document in support of this
18 paragraph, and that document is in Envelope No. 25
19 that you have with you. Could you go ahead and open
20 that?

21 And this program relates to a voucher,
22 correct?

23 A Yes.

24 Q And it's for Duragesic, which is a patch,

1 not a pill, right?

2 A Yes.

3 Q And you understand that even with this
4 voucher, a patient still needed to obtain a
5 prescription before obtaining the medication from a
6 pharmacy?

7 A Yes.

8 Q If a doctor has written the prescription
9 for Duragesic, the doctor should have made the
10 decision that that opioid is an appropriate
11 medication for treatment of pain in that patient,
12 right?

13 MR. ARBITBLIT: Objection.

14 A Again, the doctor can only make that
15 determination if they have the information necessary
16 to make that determination.

17 Q You would expect the doctor to endeavor to
18 make this decision that the opioid is an appropriate
19 medication for treatment of pain before writing this
20 prescription, right?

21 MR. ARBITBLIT: Objection.

22 A Yes.

23 Q In fact, the doctor is legally obligated to
24 do so, right?

1 MR. ARBITBLIT: Objection.

2 A Yes. But the doctor cannot fulfill that
3 legal obligation if they're being fed false
4 information about the product.

5 Q I understand that's your position. My
6 question was just a yes or no. A doctor is legally
7 obligated to exercise their judgment and determine
8 that an opioid is an appropriate medication for
9 treatment of pain before writing this prescription,
10 correct?

11 MR. ARBITBLIT: Objection. Asked and
12 answered.

13 A To me, that's not yes or no without
14 qualifying that. In order to exercise judgment, you
15 have to know what the signs show.

16 Q -- doctors are not legally obligated to do
17 that?

18 MR. ARBITBLIT: Objection.

19 A I think you would have to say your question
20 again for me. I feel like I have answered it.

21 Q I'm not trying to trick you. It's a pretty
22 simple question. I'm sure you teach it to your
23 students all the time. The question is: Are doctors
24 required to exercise their medical judgment before

1 writing a prescription?

2 MR. ARBITBLIT: Object to the prelude.
3 Objection. Asked and answered.

4 A As I stated repeatedly, it is impossible to
5 exercise medical judgment if you don't have accurate
6 information.

7 Q I'm going to try it one more time, because
8 my question (audio distortion) -- it's just --
9 (distortion) simple question. Are doctors required
10 to exercise their medical judgment when writing a
11 prescription for a patient?

12 MR. ARBITBLIT: Objection. Asked and
13 answered. Object to the prelude.

14 A I feel like I answered it already. I want
15 to give you as truthful an answer as I can, as
16 complete an answer as I can. I'm trying to give you
17 the answer that represents my true opinion so you can
18 know what that is, and I have answered it.

19 Q Okay. We'll let the judge decide if you
20 have answered it.

21 Do you know how many doctors, if any, in
22 Huntington and Cabell County saw this voucher that
23 you're looking at?

24 A No.

1 Q Do you know how many patients, if any, in
2 Huntington and Cabell County saw this voucher?

3 A No.

4 Q Do you know if the voucher was ever used
5 for a prescription of Duragesic in Huntington and
6 Cabell County?

7 A No.

8 Q And if you look at this voucher, can you
9 identify any false or misleading claims contained
10 within it?

11 A So the voucher in the middle has a
12 question, what type of chronic pain do you have, with
13 four boxes that can be checked, including lower back
14 pain and arthritis pain, as well as an option for
15 filling in whatever you want.

16 Which I think is misleading, because it
17 implies that opioids, like fentanyl, are effective
18 treatment for low back pain and arthritis pain, when,
19 in fact, there is a consensus agreement now in the
20 medical profession that opioids are not good
21 treatment for chronic low back pain or chronic
22 musculoskeletal pain. So that is misleading in my
23 opinion.

24 Q Is that the only thing on this voucher?

1 A I'm reading the backside now.

2 I think it's misleading. The statement on
3 the backside is in extremely small print, that says
4 that this should be used to relieve severe pain that
5 will last more than three months. That suggests
6 there is evidence to support the use of fentanyl for
7 the treatment of pain lasting more than three months.
8 There is no such evidence.

9 Q And that's actually a statement of
10 limitation, right? It's saying it should not be used
11 for longer than three months? You're taking issue
12 with that?

13 A Well, no, that's not what the statement
14 says. The statement says it should only be used to
15 relieve severe pain that will last more than three
16 months.

17 Q Okay.

18 A So it's proffering Duragesic as a treatment
19 for pain that lasts three -- more than three months,
20 even though there is no evidence to support that. So
21 that is misleading.

22 Q Okay.

23 A The other thing that is misleading -- yeah,
24 there's one more misleading thing, would you like me

1 to share that?

2 Q Sure.

3 A It does mention side effects, but not the
4 side effects with a risk of addiction, which I think
5 is misleading by having omitted it.

6 Q Okay. So taking these one at a time, the
7 first thing that you say is misleading is the
8 question on the front which says: What type of
9 chronic pain do you have?

10 Right?

11 A Yes, with specific check boxes suggesting
12 that fentanyl is effective treatment for something
13 like lower back pain, chronic low back pain --

14 Q This question, though, is not actually
15 making a claim about the product, correct?

16 MR. ARBITBLIT: Objection.

17 A Well, my point is I think that it is making
18 such a claim by suggesting that there are certain
19 types of chronic back pain that could be treated with
20 fentanyl, including the statement on the back that
21 "This is for people who have pain for longer than
22 three months."

23 So I think it's common sense to infer that
24 that's promoting the use of Duragesic in pain that

1 lasts longer than three months, which is the
2 definition for chronic pain.

3 Q Okay. I guess I'm just wondering, I mean,
4 this is -- it's your opinion that -- First of all, do
5 you know if this drug was FDA approved for these
6 indications?

7 MR. ARBITBLIT: Objection.

8 A So you would probably have to refresh my
9 memory, because each label is slightly different, and
10 I can't exactly remember Duragesic's label, but I am
11 happy to review it.

12 Q So you don't know one way or the other
13 whether it is FDA indicated for these conditions,
14 it's just your opinion that it's misleading?

15 MR. ARBITBLIT: Objection. Multiple
16 questions. Compound. Prelude.

17 A It is my opinion that it is misleading.
18 That's correct.

19 Q And that's your opinion without knowing
20 whether it's FDA approved for the condition?

21 MR. ARBITBLIT: Objection.

22 A Even if it were FDA approved for this
23 condition, that would be my opinion.

24 Q And then on the back, you mention the

1 statement: It should only be used to relieve severe
2 pain that will last more than three months.

3 The next sentence there is: "It should
4 only be used when other less strong medicines have
5 not been effective and when pain needs to be
6 controlled around the clock."

7 Did I read that correctly?

8 A Yes.

9 Q Thank you. And then you also mention the
10 third reason that you find this to be misleading is
11 that it does not mention addiction as a side effect.
12 When a patient picks up their prescription for
13 Duragesic, is there a warning about addiction on that
14 prescription?

15 MR. ARBITBLIT: Objection.

16 A On which part of the prescription?

17 Q In the box.

18 MR. ARBITBLIT: Objection.

19 A The FDA insert?

20 Q Yes.

21 A Yes, there is.

22 Q Thank you. Now, you've seen evidence that
23 McKesson conceptualized, designed, or bore the cost
24 for this voucher program, right?

1 A I'm sorry. I didn't quite understand. It
2 was a little garbled. Can you say it again?

3 Q Sure. You saw no evidence that McKesson
4 conceptualized this voucher program, right?

5 A That is incorrect.

6 Q So point me to that, because this is the
7 one document that you cited in your report. Where on
8 this document does it show that McKesson
9 conceptualized this voucher program?

10 MR. ARBITBLIT: Objection.

11 A Well, I'm not sure if it's on this actual
12 document, but I did see other material that made it
13 clear that McKesson was collaborating with Janssen
14 around this Duragesic patch.

15 Q Dr. Lembke, this is the only document
16 you've cited. I'm struggling to understand what the
17 evidence is for that statement. Can you help me?

18 A I don't see it here in my report, but I am
19 recalling that there was other evidence, that this
20 was a collaboration. I'm sorry. I can't find it
21 right now.

22 I do see at the bottom the words MTK, which
23 refer to McKesson, but I'm assuming --

24 Q -- Bates stamp -- got it.

1 So when you say collaboration, the ones
2 that I see on this card is on the back under pharmacy
3 processing, it says "Submit claim to McKesson, using
4 Bin No. 610500." Do you see that?

5 A Thank you. Yes. Great.

6 Q So when you say McKesson is collaborating
7 with Janssen, what you mean is at the back of this
8 voucher says that, says: "Submit claim to McKesson"?

9 A Yes.

10 Q Okay. You have no evidence that McKesson
11 designed this program, for example?

12 A I don't have evidence that McKesson
13 necessarily designed this program, but I assume that
14 they worked in collaboration with Janssen since they
15 are the ones who made the voucher and are passing out
16 the voucher.

17 Q You have no evidence that McKesson bore the
18 cost of this program?

19 A I'm not recalling the details of the
20 payment agreement on this particular product. If I
21 reviewed them, I can't remember them now.

22 Q You're not recalling them because this is
23 the one document you cited about this program, and
24 there's no indication of that, correct?

1 A Well, this is not the only document I cited
2 about this program. I also cited some sales training
3 materials from Janssen on this program.

4 Q You cited an internal Janssen document,
5 correct? In addition to this voucher?

6 A Yes.

7 Q And there is no indication on that internal
8 Janssen document, by the way, that McKesson had ever
9 seen that document?

10 A Well, it does say "Submit claims to
11 McKesson." So I'm assuming that they saw the
12 voucher. Is that what document you're talking about?

13 Q Yes. You were just referring, though, to
14 the internal sales document from Janssen that you
15 cited in romanette ii, and my question is: You have
16 no evidence -- there is no indication that McKesson
17 ever saw that document, correct?

18 A I have no evidence that they ever saw that
19 document.

20 Q Okay. And earlier today you were asked
21 some questions about whether distributors dispensed.
22 Do you remember that?

23 A Yes.

24 Q And I believe you testified earlier that

1 McKesson collaborated with Janssen, and you said to
2 dispense coupons. This is the program to which you
3 were referring, correct?

4 A Yes, among others. There was also the
5 McKesson/Janssen incentive program. And the
6 McKesson/Purdue saving card program.

7 Q Okay. Let's talk about just this one for
8 the time being. You don't mean -- You didn't mean to
9 testify that McKesson dispensed actual medication to
10 a patient, correct?

11 MR. ARBITBLIT: Objection.

12 A The physical act of dispensing is the
13 pharmacist.

14 Q Right. McKesson has never dispensed actual
15 medication to a patient in Huntington and Cabell
16 County, correct?

17 A Not physically dispensing, no.

18 Q Thank you.

19 Okay. The second program that you discuss
20 is an alleged partnership with Janssen for Nucynta.
21 You just mentioned that. It's on page 56 of your
22 report, romanette iii?

23 A Yes.

24 Q Okay. And this is also a savings card,

1 correct? That would -- Nucynta?

2 A It's both a savings card program and ten
3 free pills, which is a little different from a
4 savings card.

5 Q And it offered co-pay assistance for the
6 cost of the prescription?

7 A Yes.

8 Q You understand that even with a coupon for
9 co-pay assistance, a patient still needed to obtain a
10 prescription before obtaining the medication?

11 A Yes.

12 Q Would you agree that it's a good thing for
13 patients to be able to afford medicine that they
14 need?

15 MR. ARBITBLIT: Objection.

16 A It really depends on the circumstance and
17 the type of medicine and who's judging whether or not
18 they really need it.

19 Q If a doctor has made an informed decision
20 that a patient needs a medical prescription, would
21 you agree that it's a good thing for that patient to
22 be able to afford it?

23 MR. ARBITBLIT: Objection.

24 A If that clinical judgment was based on real

1 evidence and whether the patient's best interests,
2 both short- and long-term, then it would be good for
3 that patient to get that medicine, yes.

4 Q Okay. Do you know how many doctors in
5 Huntington and Cabell County, if any, saw this
6 savings card?

7 A No, but I do -- I have seen materials
8 showing that this savings card was disseminated in
9 West Virginia.

10 Q Where is that?

11 A That was the additional materials
12 considered, I believe.

13 Q Okay. Again, we haven't had a chance to
14 fully digest those materials. We are holding open
15 this deposition to ask you further questions about
16 that.

17 Can you identify the Bates number or any
18 other information about that document?

19 A No.

20 Q Okay. So it's your testimony that you've
21 seen some indication that this card, this savings
22 card, was distributed and -- tell me again?

23 A In West Virginia.

24 Q Okay. Do you know how many doctors in

1 Huntington and Cabell County saw it?

2 A No.

3 Q Do you know how many patients in Huntington
4 and Cabell County saw it?

5 A No.

6 Q Do you know if it was ever used for a
7 prescription of Nucynta in Huntington and Cabell
8 County?

9 A No, but I assumed that it was.

10 Q And what is that assumption based on, the
11 fact that you think it was distributed?

12 A On the fact that it was a national program
13 which was also deployed in West Virginia.

14 Q Okay. So you practice evidence-based
15 medicine, right? You said that earlier.

16 A Yes.

17 Q And I assume you endeavor to apply that
18 same rigor to your expert opinions here, right?

19 A Yes.

20 Q So when you say that you assumed that the
21 savings card was used in West Virginia, tell me what
22 evidence you have? Do you know how many times it was
23 used in West Virginia?

24 MR. ARBITBLIT: Objection. Compound.

1 A Could you rephrase your question one at a
2 time?

3 Q Sure. Can you tell me how many times the
4 savings card was used in Huntington and Cabell
5 County?

6 A No.

7 Q Okay. And have you conducted any (audio
8 distortion/garbled) to determine the impact of the
9 savings card on opioid prescribing in Huntington and
10 Cabell County?

11 A One of your words dropped out. Can you
12 repeat the question?

13 Q Have you conducted any studies to determine
14 the impact of this savings card on opioid prescribing
15 in Huntington and Cabell County?

16 A No, but McKesson conducted such studies in
17 other states where the program was first deployed and
18 it showed that average monthly claims went up by
19 198 percent when they promoted this card.

20 Q That wasn't an answer to my question, which
21 was: Have you conducted any study to determine the
22 impact of this savings card on opioid prescribing in
23 Huntington and Cabell County?

24 A Well, I was trying to answer your question

1 in a complete way, and that was my answer.

2 Q My question is whether you, Dr. Lembke,
3 have conducted a study to determine the impact of
4 this savings card on opioid prescribing in Huntington
5 and Cabell County?

6 MR. ARBITBLIT: Objection.

7 A No.

8 Q Thank you. The third program is also on
9 page 56, and it's at romanette iv. And you cite one
10 document. It's actually -- let's see, in the
11 envelope marked 29 that you have in front of you.
12 And it's an alleged partnership with Purdue for
13 Butrans. Do you have that in front of you?

14 A Yes.

15 Q Okay. And this is a savings card program
16 for Butrans Transdermal. Does that sound right?

17 A Yes.

18 Q This is a patch again, not a pill, right?

19 A Yes.

20 Q And the savings card offers co-pay
21 assistance for the cost of the prescription?

22 A Yes.

23 Q You understand that Butrans is brand name
24 Buprenorphine?

1 A Yes.

2 Q And Buprenorphine can be used to treat
3 opioid addiction, right?

4 A Yes.

5 Q In your opinion --

6 A Although this particular product is not FDA
7 approved to treat opioid addiction.

8 Q Have you ever prescribed this product to
9 treat opioid addiction?

10 A No.

11 Q Are you aware of other doctors prescribing
12 this to treat opioid addiction?

13 A No.

14 Q Okay. And you understand, again, that even
15 with this savings card, a patient still needed to
16 obtain a prescription before obtaining the
17 medication?

18 A Yes.

19 Q This letter that we're looking at is (audio
20 distortion) by Purdue, not McKesson, right?

21 MR. ARBITBLIT: Objection.

22 BY MS. RODGERS:

23 Q It's not a trick question --

24 A Yes, it says Purdue at the bottom of the

1 letter, so I'll take your word for it. But that
2 particular item was not drafted by Purdue, although
3 more broadly, this was clearly a collaboration
4 between McKesson and Purdue.

5 Q And I think you just mixed up some words.
6 You said this particular document, this letter, was
7 not drafted by McKesson. That's what you meant,
8 right?

9 A Just this very front piece. I can't see
10 McKesson's imprint on here, so I really don't want to
11 assume that I know who wrote this, one way or
12 another.

13 Q Okay. And on that first page there is a
14 boxed warning, correct?

15 A Yes.

16 Q It's bold and underlined, and there is a
17 note about the potential for abuse of this product.
18 Do you see that?

19 A Yes.

20 Q And also, if you flip to the fifth page of
21 this document -- unfortunately they're not
22 numbered -- do you see another black box warning,
23 right?

24 A Yes, I do.

1 Q And that's also a warning about the
2 potential for abuse of the product, correct?

3 A Yes.

4 Q Do you know how many doctors in Huntington
5 and Cabell County, if any, saw this savings card?

6 A No.

7 Q Do you know how many patients in Huntington
8 and Cabell County, if any, saw this savings card?

9 A No.

10 Q Do you know if it was ever used for
11 prescription of Butrans in Huntington and Cabell
12 County?

13 A No.

14 Q Okay. Let's look at the (audio
15 distortion) --

16 A Sorry. Your words dropped off.

17 Q Can we look at --

18 MS. RODGERS: I think somebody with an
19 area code of 650 is not on mute. If they could go on
20 mute, it might help the sound quality.

21 Or is that you, Dr. Lembke?

22 THE DEPONENT: I don't think it's me,
23 but...

24 MS. RODGERS: Well, if everyone could

1 go on mute except for (audio distortion), that would
2 be helpful.

3 BY MS. RODGERS:

4 Q And so the fourth program is on (audio
5 distortion) your report on page 57 --

6 A Sorry. Your words dropped.

7 Q Okay. Can you turn to page 57 of your
8 report, romanette v, and this is about an alleged
9 partnership with Purdue regarding Butrans.

10 Do you see that?

11 A Yes.

12 Q Okay. And you cited one document in
13 support of this paragraph. And, fortunately, it's
14 not in your set. I think I emailed it to plaintiff's
15 counsel yesterday. I don't know if you received it.

16 But maybe, Clayton, if you could pull it
17 up?

18 BY MS. RODGERS:

19 Q So, again, this is for Butrans, the patch,
20 correct?

21 A Yes.

22 Q And this program was to involve, as you
23 noted in your report, an advertisement that linked
24 Butrans website, an online ordering portal that

1 McKesson hosted for pharmacies, right?

2 A Yes.

3 Q It's not a platform for patients?

4 A Yes, that's correct. That's my
5 understanding.

6 Q Do you know how many pharmacies in
7 Huntington and Cabell County, if any, saw this ad on
8 the online ordering portal?

9 A No.

10 Q And is there anything in your report that
11 indicates that the information in this advertisement
12 was false or misleading?

13 A Well, you don't have the ad there, right?
14 You have the agreement.

15 Q Right. You haven't cited the ad. Have you
16 seen the ad, Dr. Lembke?

17 A I don't believe I've seen the ad.

18 Q Okay. You didn't ask to see it -- or did
19 you?

20 A Yes, I did.

21 Q You weren't provided with it?

22 A No.

23 Q Okay. So is there any evidence that you
24 have that anything in this advertisement was false or

1 misleading?

2 A Well, I don't have it so I can't evaluate
3 it.

4 Q Okay. And I'm just trying to get a clear
5 answer to that. You don't have the ad so you have no
6 evidence that anything here was false or misleading,
7 correct?

8 A Because I didn't see it.

9 Q Is that correct?

10 A Yes. Because I didn't see it, I can't
11 evaluate it.

12 Q Okay. And you haven't conducted any study
13 to determine the impact of this ad, which was
14 directed at pharmacists, on opioid prescribing in
15 Huntington and Cabell County?

16 A That's correct.

17 Q Okay. Now, the fifth program is an alleged
18 partnership with Teva regarding Actiq and Fentora.
19 It's on page 56 at romanette ii.

20 And if you could open No. 26, the envelope
21 you have. And this is a contract that you cite in
22 your report. Again, it's the only document for this
23 program, correct?

24 A Yes.

1 Q Okay. And the contract covers services
2 related to Actiq and Fentora, one called RxBulletin
3 and then one called RxMail.

4 Do you see that?

5 A Yes.

6 Q And the RxBulletin was to involve three
7 emails. Do you see that?

8 A Yes, that's also how I'm reading it, yes.

9 Q Okay. And do you understand that those
10 emails were to be directed at pharmacists?

11 A Yes, I do.

12 Q And then RxMail is the second service, and
13 that service included mailings to top independent
14 pharmacies; is that your understanding?

15 A Yes.

16 Q Okay. And I just want to direct your
17 attention to the bottom of that first page. Do you
18 see where it says: "The content of any document,
19 material, or information provided by Teva to McKesson
20 for inclusion in the program, supplier content, under
21 this agreement is the sole responsibility of Teva,
22 and Teva represents and warrants that the supplier
23 content complies with applicable law -- all
24 applicable laws."

1 Did I read that correctly?

2 A Yes.

3 Q Do you know how many pharmacies, if any, in
4 Huntington and Cabell County saw the RxBulletin or
5 RxMail referred to in this document?

6 A No.

7 Q And do you have any evidence that there
8 were any false or misleading claims contained in
9 those RxBulletin or RxMail offerings?

10 A I wasn't able to evaluate the actual
11 mailing. I would be happy to do that.

12 Q You asked for it and did not receive those
13 documents?

14 A Yes.

15 Q Okay. Are you familiar with REMS?

16 A Yes.

17 Q REMS is a risk management tool, right?

18 A Risk Evaluation and Mitigation Strategy.

19 Q It's intended to help reduce improper usage
20 of opioids; is that right?

21 A That was the intent, yes.

22 Q Do you think it's important for a
23 pharmacist to know about REMs requirements?

24 MR. ARBITBLIT: Objection.

1 A REMS is directed toward physician
2 prescribers. I think it's important for a pharmacist
3 broadly to know about the addictive risk of opioids.
4 I don't know if they specifically need to know what
5 mechanisms are being used to educate physicians.

6 Q Do you think it's good for pharmacists to
7 know about REMs requirements?

8 MR. ARBITBLIT: Objection.

9 A Again, pharmacists are asked to know a lot
10 of things, just like doctors are. I'm not sure I
11 would prioritize their knowing about REMs above other
12 important aspects of opioids.

13 Q Okay. Interesting. You understand that
14 these messages were to let pharmacists know about
15 REMs requirements?

16 A I didn't know that.

17 Q Okay. If you look at document in the
18 folder No. 27 that you have.

19 Have you seen this document before?

20 A I may have done -- I've reviewed a lot of
21 documents, including documents regarding REMs
22 specifically for Actiq, but I don't know if I've seen
23 this exact document.

24 Q And on the front page here it says Actiq

1 and Fentora, the two drugs that we had just been
2 talking about. And if you look at the page ending in
3 3378, you'll see it looks very familiar to what we
4 just saw, right? This is the same program?

5 A Yes.

6 Q Okay. And if you turn back to the first
7 page of this document, which ends in 3375?

8 A Yes.

9 Q You see that the objective is (audio
10 distortion) pharmacists regarding new REMS
11 requirements for Actiq and Fentora. Do you see that?

12 A Yes.

13 Q Put that document away.

14 I want to turn to the sixth and seventh
15 programs that you talk about in your report, and they
16 relate to pharmacy intervention programs. There is
17 one with Purdue for Butrans that you reference on
18 page 60 of your report.

19 But before we get to that, I just want to
20 ask some background questions about these programs.
21 A pharmacy intervention program is a program in which
22 participating pharmacists provide certain educational
23 information about a prescription medicine, correct?

24 A I wouldn't characterize it in that way. I

1 think that's too limited a characterization.

2 Q How would you characterize it?

3 A As a promotional activity.

4 Q Is a component of what you are
5 characterizing this promotional activity that a
6 pharmacist provides certain educational information
7 to a patient?

8 MR. ARBITBLIT: Objection.

9 A I wouldn't characterize it that way, no.

10 Q What are you taking issue with?

11 A My impression is that this pharmacy
12 intervention program is a way to covertly promote
13 certain opioid products and encourage patients to go
14 on to higher doses, or to continue on those
15 medications instead of other alternatives.

16 Q Okay. And that impression that you've just
17 stated is based on the documents that you cited in
18 your report, correct?

19 A Yes.

20 Q Okay. We're going to look at those. This
21 conversation between pharmacists and patients occurs
22 when the patient shows up at the pharmacy to pick up
23 their prescription, right?

24 A Yes.

1 Q Okay. So before anything -- any coaching
2 session or anything related to these programs would
3 occur, several things would have had to happen.
4 First, a physician would have had to consult with the
5 patient, correct?

6 A Yes.

7 Q And that physician would have had to decide
8 to prescribe a medicine to the patient, right?

9 A Yes.

10 Q The patient would have had to choose to
11 fill the prescription, right?

12 A Yes.

13 Q And the patient would have had to choose to
14 go to a pharmacy to pick up that prescription, right?

15 A Yes.

16 Q Only then, when the patient went to the
17 pharmacy, could any conversation occur under these
18 programs that you're citing in your report, correct?

19 MR. ARBITBLIT: Objection.

20 A Yes.

21 Q Would you agree that some educational
22 conversations between pharmacists and patients could
23 be helpful for certain medications?

24 MR. ARBITBLIT: Objection.

1 A It would really depend on how the
2 pharmacist was coached, what they were coached to
3 say, whether or not that was based on legitimate
4 medical science.

5 Q Okay. But it could be helpful for some
6 medications?

7 MR. ARBITBLIT: Objection.

8 A Hypothetically, yes. It would depend on
9 the medicine, and it would depend on what they said.

10 Q And would you agree that it's important for
11 patients to take prescription medications as directed
12 by their doctor?

13 A It's the doctor's decision to prescribe
14 that medication if the claims were based on science
15 and medical necessity, then it would be good for the
16 patient to take it. But if it wasn't, then it
17 wouldn't be good for the patient to take it.

18 Q So -- Thank you. I appreciate that.

19 If one of your patients, for example, was
20 taking buprenorphine for addiction treatment, you
21 wouldn't want that patient to stop taking it without
22 consulting you, right?

23 MR. ARBITBLIT: Objection.

24 A It would depend on the reason why they

1 stopped taking it.

2 Q So you would be comfortable with them
3 terminating that medication without consulting you?
4 Wouldn't you want to know why?

5 A Yes, if they had good reason, yes, I would
6 be okay with that.

7 Q Okay.

8 A And I would want to know why, and I would
9 ask them.

10 Q Would you want to know about it before they
11 stopped taking it or after?

12 A Ideally before, but after is okay too, if
13 the circumstances warranted them stopping, before
14 consulting me.

15 Q If a patient is taking buprenorphine for
16 addiction treatment and they're not ready to stop
17 taking that, but they stopped taking it suddenly,
18 that could actually increase the chances of relapse,
19 correct?

20 MR. ARBITBLIT: Objection.

21 A It would depend on the patient.

22 Q You're saying if someone needs to take
23 buprenorphine for addiction treatment, and they stop
24 taking it suddenly, that would not increase their

1 chances of relapse?

2 MR. ARBITBLIT: Objection.

3 A So it's all about weighing the risks and
4 benefits. And if the risks outweigh the benefits
5 such that a patient needed to abruptly stop a
6 medication I was prescribing them, that would be the
7 right thing to do, even without consulting.

8 Q That didn't answer my question, which was:
9 Would it increase the chance of relapse?

10 A Yeah, I already answered that.

11 Q Can you answer it again?

12 MR. ARBITBLIT: Objection.

13 A It would depend on the circumstance.

14 Q If a patient is taking buprenorphine for
15 addiction treatment and they need it, under what
16 circumstance would it not increase the chance for
17 relapse if they stopped taking it suddenly?

18 A If, for example, they were overdosing on
19 that medication.

20 Q So if they weren't taking it as prescribed?

21 A No. Overdose can happen even when patients
22 are taking their opioids just as prescribed.

23 Q Have you ever had a patient overdose when
24 they were taking an opioid as you have prescribed it

1 under your care?

2 A I know of patients that have been under my
3 care who have overdosed when taking therapeutic
4 medications just as prescribed.

5 Q Okay. So the Purdue program that you
6 reference on page 61 here was for Butrans, and again,
7 that's brand name buprenorphine, correct?

8 A Yes, it is.

9 Q And you testified earlier today that this
10 program was evidence that McKesson communicated to a
11 doctor or a pharmacist that the risk of addiction to
12 prescription opioids is rare or less than 1 percent.
13 Do you remember that?

14 A I'm sorry. Can you repeat that?

15 Q Sure. You testified earlier today that
16 this program, this pharmacy intervention program, was
17 evidence that McKesson, quote, "communicated to a
18 doctor or a pharmacist that the risk of addiction to
19 prescription opioids is rare or less than 1 percent."

20 Do you remember that?

21 A Yes.

22 Q And you cite one document (audio
23 distortion) to this program. It's in Envelope
24 No. 28.

1 Do you have that in front of you?

2 A Yes.

3 Q This document appears to be on a type of
4 summary of the program, correct?

5 A Yes. However, this document lacks the
6 actual coaching that went on.

7 Q Right. I'm glad you mention that. So the
8 second page, under "Pharmacy Brand Kit," there is a
9 reference to the coaching guide. And I think that's
10 what you're talking about, right?

11 A Yes.

12 Q Did you ask to see that coaching guide?

13 A Yes.

14 Q And you weren't provided with it?

15 A I was provided with it.

16 Q You didn't cite it in your report. Is
17 there a reason why you didn't cite it?

18 A Because I was provided with it just
19 yesterday.

20 Q Okay. So let's look at the coaching guide.
21 Clayton is going to pull it up. It's Bates No.
22 PPLP003299959. And again, does this appear to be the
23 coaching guide that you were referring to for the
24 Butrans thermal system?

1 A Can you scroll through the whole thing so
2 that I can see if it looks like what I reviewed?

3 Yes.

4 Q Okay. So on the first page, there is again
5 a black box. And it's underlined and bolded and
6 says: Addiction abuse and misuse.

7 Do you see that warning?

8 A Yes.

9 Q Okay. And if you turn to --
10 Clayton, the second page. Right there.
11 That's perfect.

12 Do you see here that the pharmacist (audio
13 distortion) Do you see that it says under No. 3:
14 "May I share some important information with you
15 around using the Butrans patch."

16 Do you understand that's what the
17 pharmacist is supposed to say?

18 A I do understand that, yes.

19 Q Okay. And then it goes on. "This is a
20 strong prescription pain medicine that contains an
21 opioid narcotic that is used to manage pain severe
22 enough to require daily around-the-clock treatment
23 with an opioid when other pain treatments, such as
24 non-opioid pain medicine or immediate-relief opioid

1 medicine, do not treat your pain well enough or you
2 cannot tolerate them. Butrans is a long-acting
3 extended-release opioid medicine that can put you at
4 risk for overdose and death. Take your dose
5 correctly as prescribed (audio distortion) at risk
6 for opioid addiction, abuse, and misuse that can lead
7 to death."

8 Do you see that?

9 A Yes.

10 Q So the pharmacist under this training
11 program warns the patients about the risk of
12 addiction, correct?

13 A Yes.

14 Q Can you point to any evidence in this
15 program that McKesson communicated to a doctor or a
16 pharmacist a risk of addiction to prescription
17 opioids is rare or less than 1 percent?

18 That was your testimony earlier this
19 morning.

20 A No.

21 Q Okay. Can you point to any evidence that
22 as part of any program McKesson communicated to a
23 doctor or a pharmacist that the risk of addiction to
24 prescription opioids is rare or less than 1 percent?

1 A So I do believe that McKesson's
2 collaboration with Janssen, that involves giving out
3 five free fentanyl patches, that that promotional
4 campaign, based on material I saw, understated the
5 risks.

6 Q You're talking about one of the programs
7 that we already looked at today; is that right?

8 A Yes.

9 Q And was there anything in that document
10 that said that McKesson communicated to a doctor or a
11 pharmacist that the risk of addiction to prescription
12 opioids is rare or less than 1 percent?

13 A Not McKesson directly, but the sales rep
14 promoting the patches.

15 Q Was that on the internal Janssen document
16 that you (audio distortion) in your report?

17 A Yes.

18 Q Okay. And, again, you testified that
19 you're not -- you have no evidence that McKesson ever
20 saw that document or was involved in the preparation
21 of that document, correct?

22 A That's correct.

23 Q Okay. Turning back to this Butrans
24 program, can you identify any pharmacy in Huntington

1 and Cabell County that was part of this pharmacy
2 intervention program?

3 A No.

4 Q And can you identify any patients in
5 Huntington and Cabell County that received a
6 behavioral interview regarding their prescription
7 opioid treatment as a result of this pharmacy
8 intervention program?

9 A No.

10 Q Okay. Now, on page 58 of your report you
11 discuss an alleged pharmacy intervention program with
12 Janssen for Nucynta. Do you recall that?

13 A Yes.

14 Q If you could open up document No. 24.

15 MR. ARBITBLIT: Before you do that,
16 can we find out how much time is left?

17 VIDEOGRAPHER: I'm at 6 hours, 52
18 minutes. Let me double-check when we take a break.

19 MR. ARBITBLIT: We've got eight
20 minutes left, so we don't need a break.

21 BY MS. RODGERS:

22 Q If you could turn to page 1414. Are you
23 there?

24 A Yes.

1 Q And I believe this is what you cite in your
2 report, correct?

3 A Yes. This entire document, yes.

4 Q Yes. This document provides a general
5 description of what a pharmacy intervention program
6 for Janssen could entail, right?

7 A Yes.

8 Q Not a signed contract though, right?

9 A No.

10 Q Can you identify any evidence that this
11 program actually occurred at all?

12 I'm going to ask to go off the record if
13 you're going to flip through the whole document.

14 A No.

15 Q Okay. Can you identify any evidence that
16 the program occurred in Huntington and Cabell, yes or
17 no?

18 THE DEPONENT: Actually can we go off
19 the record so I can actually flip through the
20 document?

21 VIDEOGRAPHER: The time is 6:44.
22 We're now going off the record.

23 (Pause in proceedings)

24 VIDEOGRAPHER: The time is 6:46.

1 We're now back on the record.

2 A So in answer to your question is there any
3 evidence that the pharmacy intervention program was
4 ever implemented, I direct you to page 1415.

5 The headline there is "McKesson Has Built
6 one of the largest adherence networks, the sponsored
7 clinical services networks."

8 And then they proceed to talk about that
9 they have 1500 independents and 1300 chain
10 pharmacies, and growing each month. That leads me to
11 believe that this is an established program.

12 Q And I understand that this page is
13 referring to McKesson's services generally. My
14 question was whether you have any evidence that this
15 PIP program with -- about Nucynta actually occurred.

16 A I'm sorry. I think your actual question
17 before was whether or not the PIP program actually
18 occurred. So the answer to that is yes.

19 I don't have any specific information on
20 Nucynta and the PIP program. So the answer to that
21 is no.

22 Q Okay. So you can't identify any patient in
23 Huntington and Cabell County who received a
24 behavioral interview regarding their prescription

1 opioid treatment as a result of this PIP program?

2 A No.

3 Q At the top of page 58 of your report, you
4 said: "It is ironic that the Opioid Pharmaceutic
5 Industry used, parentheses, (is using) these
6 techniques to get patients to continue to take
7 opioids under the guise of promoting medications
8 adherence."

9 Do you see that?

10 A Yes.

11 Q And aside from the key programs that we
12 just looked at, the Butrans one and the Nucynta one,
13 what is your basis for saying that distributors are
14 still conducting programs related to prescription
15 opioids?

16 A I don't have any reason to believe that
17 these programs have been terminated, so I believe
18 them to be ongoing. If there is information that
19 these programs have been terminated, I'm happy to
20 look at that.

21 Q Well, you don't even know if the Nucynta
22 one ever started, right? That's what you testified
23 to earlier.

24 A I don't know specifically if the Nucynta

1 adherence motivational interviewing program is
2 ongoing. That's true.

3 Q That wasn't my question. You don't know if
4 the Nucynta program ever started, right?

5 A No, that's not true. There's evidence
6 showing that the Nucynta coupon program was
7 implemented in many states.

8 Q And I'm talking now about this behavioral
9 interview program that's referenced on page 58, and
10 it's -- you're saying that the Opioid Pharmaceutic
11 Industry is using these techniques. I'm asking what
12 your evidence is of that.

13 A Well, you showed me the coaching plan for
14 Butrans patch. So that's a piece of evidence. And
15 then this document makes it clear that the pharmacy
16 intervention program has been built and is active.

17 Q Okay. But as for the Butrans, you don't
18 know if that program is still going, correct?

19 A I don't know if it's still going, no.

20 Q Okay. And as to the Nucynta PIP program
21 that we just looked at, you don't know if that ever
22 started, correct?

23 A That's correct.

24 Q And are you aware of any other behavioral

1 interview programs related to prescription opioids
2 that any distributor is currently running?

3 A No.

4 Q Okay. Thank you. So we just talked about
5 all seven of the programs that are contained in your
6 report that relate to McKesson. I just have a couple
7 of final questions for you.

8 The first is that pharmacists don't
9 prescribe opioids, right?

10 A That's correct.

11 Q And there is no evidence that McKesson
12 sends any of the communications that we just looked
13 at to patients, right?

14 A No.

15 Q No, that's correct?

16 A No, that's correct. So in my report I cite
17 the McKesson call campaign, behavioral call campaign,
18 wherein McKesson representatives directly outreach to
19 patients with phone calls. I don't know what was
20 discussed at that phone call, but I think it's
21 relevant that --

22 Q Where is that in your report?

23 A Page 61. They describe it as
24 patient-centric behavioral coaching. "Agents make

1 outbound calls to patients in order to uncover
2 personal barrier and provide appropriate messaging
3 content to help overcome those barriers. And these
4 efforts are, quote, aligned to address Janssen's
5 needs," unquote.

6 Q And I think that's the document that we
7 were just looking at, right? That's No. 24?

8 A I'm sorry. I don't know which document is
9 No. 24.

10 Q It's this document (indicating to camera)?

11 A Right. Yes.

12 Q Okay. And you're citing for this paragraph
13 that McKesson is directly -- the proposition that
14 McKesson directly targets patients, that PIP program
15 that we just looked at, correct?

16 A Yes.

17 Q And that -- and that's the program that you
18 testified you're not sure it ever started, correct?

19 A No. I corrected that testimony regarding
20 the PIP program itself. I said that I thought there
21 was evidence that it had started, so -- and I think
22 there's evidence in that document that the behavioral
23 call campaign was also underway.

24 Your question was regarding whether or not

1 behavioral coaching occurred around Nucynta, and to
2 that I said I wasn't aware of specific evidence
3 saying whether or not that had started. But the PIP
4 program had clearly started.

5 Q What is your evidence -- and again, we can
6 go off the record -- that the PIP program for Nucynta
7 started?

8 MR. ARBITBLIT: I think we're over
9 seven hours now, aren't we?

10 MS. RODGERS: I think this testimony
11 is conflicting. If you would allow me to just
12 clarify here, it would be helpful.

13 MR. ARBITBLIT: Well, if we're over
14 seven hours --

15 A At page 1415: "McKesson has built one of
16 the largest adherence networks." And then they
17 describe it. And this is under the section
18 describing their PIP program. "1500 independents,
19 1300 chain pharmacies, and growing each month."

20 Q Understood. So this is, again, you're
21 referring to the general description of McKesson
22 services, not a specific program that McKesson had
23 related to prescription opioids where McKesson sent
24 communications to patients, correct?

1 A There was a specific coaching program
2 around Butrans.

3 Q Correct. Yes.

4 A Okay. And there was a specific direct
5 patient call program. I don't have evidence that
6 that involved opioids necessarily, but the call
7 program did exist.

8 Q Okay.

9 Just three more questions. We talked
10 about, you know, whether you had evidence that these
11 programs ran in Huntington and Cabell County, and I
12 won't go back over that again. But even assuming
13 that McKesson carried through with any of these
14 programs in Huntington and Cabell County, you didn't
15 conduct any analysis to show what effect, if any,
16 those programs had on the population of opioid users
17 in Cabell County and Huntington, right?

18 A That is correct.

19 Q Thank you. And you did not conduct any
20 analysis to show what effect, if any, McKesson's
21 programs had on the dose and duration of opioid use
22 in Cabell County and Huntington, correct?

23 A That is correct.

24 Q And one more question: You did not (audio

1 distortion) conduct any analysis to show what effect,
2 if any, McKesson's programs had on the risk of opioid
3 misuse, addiction, dependence, and death in
4 Huntington and Cabell County, correct?

5 A For the first part of that question you
6 dropped out. Could you repeat the question?

7 Q Yes. You did not conduct any analysis to
8 show what effect, if any, McKesson's programs had on
9 the risk of opioid misuse, addiction, dependence, and
10 death in Huntington and Cabell County, correct?

11 A No quantitative analysis, no.

12 MS. RODGERS: Thank you. I have no
13 further questions.

14 MR. ARBITBLIT: I have just a couple.

15 EXAMINATION BY COUNSEL FOR PLAINTIFFS:

16 BY MR. ARBITBLIT:

17 Q Doctor, could you take a look at your
18 report at page -- starting with 195, Appendix I.B,
19 referring to Teva/Cephalon Misleading Messaging.

20 A Yes. I'm looking at it.

21 Q Do you include from pages 195 through 206
22 on what you consider to be misleading messaging from
23 Teva/Cephalon, including about Actiq and Fentora,
24 that you were not asked about today?

1 A Yes.

2 Q And if you could take a look at Exhibit 24,
3 which is the McKesson Manufacturer Marketing --
4 excuse me, it's No. 27. No. 27, McKesson
5 Manufacturer Marketing Documents prepared for
6 Cephalon, Actiq and Fentora proposal, dated
7 January 19, 2012. Do you have that?

8 A Is it this one?

9 Q Yes. If you could take a look at the page
10 that ends in -- it's page 3 of 6 and ending 3376 in
11 the lower right.

12 A Okay.

13 Q And if you could look at the third
14 paragraph from the bottom of the page, I'll just read
15 what it says:

16 "McKesson partners," actually, I'll start
17 one paragraph above.

18 "Delivering an unmatched combination of
19 communication, promotion, distribution options, plus
20 targeted analytics of exclusive data, McKesson will
21 enable Cephalon to set strategies that prioritize
22 opportunities, optimize resources, and maximize
23 profitability."

24 Did I read that correctly?

1 A Yes.

2 Q And if you look at the next paragraph, it
3 says: "McKesson partners with pharmaceutical
4 manufacturers, such as Cephalon, to define and
5 execute customized strategies, targeting key
6 awareness, sales, and distribution goals at all
7 stages of the product life cycle."

8 Did I read that correctly?

9 A Yes.

10 MR. ARBITBLIT: That's all I have.
11 Thank you. Thank you for your time, Doctor.

12 THE DEPONENT: You're welcome.

13 VIDEOGRAPHER: The time is
14 7:00 o'clock. We're now going off the record. This
15 concludes the deposition.

16 (Signature having not been waived, the deposition
17 of ANNE LEMBKE, MD, was concluded at 7:00 p.m.)

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1 STATE OF WEST VIRGINIA,
2 COUNTY OF KANAWHA, to-wit:

3
4 I, Twyla Donathan, RPR, a duly commissioned
5 Notary Public for the County and State herein, do hereby
6 certify that the foregoing deposition of ANNE LEMBKE, MD,
7 was duly taken by and before me via Zoom video
8 conferencing at the time and for the purpose specified
9 in the caption hereof, the said witness having been by me
10 first duly sworn.

11 That the foregoing is a true, correct, and
12 full transcript of the testimony adduced to the best of my
13 ability, given the challenges of Zoom video-conferencing
14 audio/sound interferences, as taken by me in shorthand
15 notes and thereafter accurately transcribed;

16 I further certify that I am neither attorney
17 or counsel for, nor related to or employed by, any of the
18 parties to the action in which this deposition is taken;
19 and further, that I am not a relative or employee of any
20 attorney or counsel employed by the parties or financially
21 interested in the action; and that the attached transcript
22 meets the requirements set forth within Article 27,
23 Chapter 47 of the West Virginia Code.

24 IN WITNESS WHEREOF, I have hereunto set
my hand this 21st:



TWYLA DONATHAN

Registered Professional Reporter

My commission expires September 11, 2022.

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

September 22, 2020

To: Don C. Arbitblit, Esq.

Case Name: City Of Huntington v. Amerisourcebergen Drug Corporation

Veritext Reference Number: 4255516

Witness: Anne Lembke, M.D. Deposition Date: 9/17/2020

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4255516

CASE NAME: City Of Huntington v. Amerisourcebergen Drug Corporation, Et Al.

DATE OF DEPOSITION: 9/17/2020

WITNESS' NAME: Anne Lembke, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

Date

Anne Lembke, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 4255516

CASE NAME: City Of Huntington v. Amerisourcebergen Drug Corporation, Et Al.

DATE OF DEPOSITION: 9/17/2020

WITNESS' NAME: Anne Lembke, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

Date

Anne Lembke, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

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ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 4255516

PAGE/LINE(S) / CHANGE /REASON

Date Anne Lembke, M.D.
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DAY OF _____, 20____ .

Notary Public

Commission Expiration Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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